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DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of The Ohio State University

By

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* * * * *

The Ohio State University

1976

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CHAPTER I
INTRODUCTION

Background of the Problem

Institutional administrators have long been charged with the responsibility of conducting employee orientation, and for providing a variety of effective training programs for attendant personnel. Moreover, it is generally expected that these personnel training programs will facilitate employee adjustment to institutional milieu and positively effect the efficient operation of institutional programs. The philosophy, objectives, content, and methods of delivery for past training programs have been aptly documented by Pleydell (1950); Roselle (1950); Kline and Eaton (1952); Johnston and Von Bulow (1953); and Staley (1955). In more recent times, several state departments have developed worker training programs that espouse a philosophy of short-term care for their residents. However, these states, i.e. Colorado (1974); Florida (1975); Georgia (1975); Louisiana (1975); and Michigan (1975) are only now in the developmental stages of their training programs.

At a minimum, however, most of the preparatory courses reported in the literature have reflected the administrator's attempt to assist worker personnel adaptation to the institutional setting through two major approaches. First, most of the training programs place their
emphasis on attempting to assist prospective attendant personnel in learning their basic on-the-job responsibilities, as well as those of various institutional departments and personnel. Secondly, training programs traditionally assist attendant personnel in learning basic, long-term custodial care, i.e. first aid; housekeeping and sanitation; feeding; toileting; grooming (and other daily living skills). However, a search of the literature revealed that training programs have generally ignored employee attitudes toward the institution (for example, New Jersey, 1959) and its residents; employee attitudes toward an institution's specific training program; the differences in the skills and knowledge of ward personnel, etc. Moreover, these training programs ignore several underlying, important and emerging concepts which, to a large degree, dictate procedures within an institutional setting such as providing for the civil rights of all residents; a working knowledge of such important program and organizational concepts such as unitization; assuring that each resident is confined in the least restrictive environment; normalization; and, the understanding of the important difference between the developmental and care models of institutional programming.

Finally, and perhaps most importantly, preparatory programs of this nature are usually not evaluated for their effectiveness. For example, Shafter (1957) indicates that employees who take these courses are not given the opportunity to evaluate what in the total program assisted them the most; that content which needed improvement; and, specific content which might be eliminated from use in the future.
Barnett and Bensberg (1964) add to this viewpoint by stating, "Thus, the participation of both trainer and attendant in the planning and carrying out of the evaluation process is vitally important." (p. 227).

The State of Ohio's current attendant training program (The Ohio Psychiatric Aide Manual, 1967) is no exception. Currently, Ohio has one training program for both its Mental Health and Mental Retardation Aides (referred to as the Psychiatric Aide Series). While there surely are commonalities within each of these programs, many responsibilities, understandings, procedures and some necessary skill acquisitions are, simply, quite different. Moreover, the underlying purpose of an aide within the areas of mental health and mental retardation is different. Mental Health is working for restoration of one's mental adjustment process, as contrasted to mental retardation where the programmatic thrust is one of development of basic habilitation skills not previously possessed, but needed to function at optimum levels in either institutional or community environments. In the past many preparatory programs emphasized only good long-term care and maintenance of health. This approach is referred to as the medical model (President's Committee on Mental Retardation, 1975; Roos, 1971; and Wolfensberger, 1969).

Three recent developments have necessitated updating and improvement of the existing Ohio Psychiatric Aide Manual (1967). One is the recent passage and implementation of Ohio Revised Codes 5123.98 - 5123.67 (hereinafter referred to as S.B. 336), which outlines the State of Ohio's responsibilities toward the mentally retarded and developmentally disabled. These far reaching changes in S.B. 336 (promulgated July 1, 1974), mandate wholesale changes in treatment, care, programming, and the civil
rights of the retarded. Especially good examples of these changes can be seen in the admission; holding; and, discharge policies outlined within Senate Bill 336. Several of these major categories are listed below:

(a) Basic Civil Rights of the Mentally Retarded.
(b) Individual Habilitation Planning and Programming.
(c) Voluntary and Involuntary Admissions.
(d) Procedures for Court Commitment.
(e) Short-Term Commitments.
(f) Probable Cause Hearings.
(g) Due Process for Court Hearings.
(h) Comprehensive Evaluation and Right to Treatment.
(i) Informed Consent.
(j) Confidentiality of Records.
(k) Freedom of Religion.
(l) Resident Abuse, Staff Liability and Alleged Client Abuse.
(m) Guardianships.
(n) Professional and Staffing Ratio Standards.
(o) Trial Visits and Post-Discharge Care.
(p) Provisions for Adequate Medical Treatment of Residents.

The purpose in listing the above-mentioned categories is twofold: one, to illustrate the complexity of Senate Bill 336, as amended; and two, to point out that at the present time these standards are not included in staff development, at the attendant level, within Ohio's institutions for the mentally retarded and developmentally disabled. These standards (see Appendix A) are mandated by the Department of
Mental Health and Mental Retardation's executive orders, which provide specific guidelines for the development of such preparatory programs. The purposes of these standards (as outlined in the Departmental Executive Orders) are:

(a) to establish mandatory inservice training for all direct-care personnel in the Department of Mental Health and Mental Retardation's institutions;

(b) to insure adequate basic training for each employee caring for the mentally retarded and developmentally disabled; and,

(c) to upgrade the qualities of client care by developing employee skills through continuing inservice educational programs.

Finally the adoption of these standards insures that each employee functioning at the ward level (and in daily contact with the client) will receive sufficient training to insure that he or she has the necessary skills to treat and care effectively for those clients in his or her charge.

A second recent development will also have a profound effect on training programs for Ohio's direct-care personnel. Recent Departmental executive orders mandating the transfer of a large number of mental health ward personnel to institutions for the mentally retarded and developmentally disabled have provoked considerable alarm among the respective Divisions within the Department of Mental Health and Mental Retardation (see Appendix B). Most of this alarm is centered around the fact that the mental health attendant, trained to work with the
mentally ill, does not have appropriate training to work with the mentally retarded.

A third development lies in Ohio's struggle to meet national standards associated with quality care and habilitation; and, the ultimate eligibility for capture of federal medicaid and other third-party payments for people in institutions, which has as its final goal monetary assistance in the upgrading of programs and services to the institutionalized mentally retarded. Presently, none of the institutions for the mentally retarded and developmentally disabled meet the standards of care outlined by the Joint Committee on Accreditation of Hospitals for the mentally retarded (JCAH). The estimated loss of revenues under both medicaid and JCAH is in the millions of dollars—all of which could be utilized for more effective institutional programming and facility development.

The Joint Commission on Accreditation of Hospitals "was established to improve, through a national, voluntary program of accreditation, the quality of services provided the mentally retarded and developmentally disabled. The accreditation process has two major aspects:

(a) Setting standards for services; and,

(b) Determining the degree to which any given service complies with such standards." (JCAH, 1973, p. viii).

In addition to accreditation standards on administrative policies and practices and resident living, JCAH provides a state department of Mental Health and Mental Retardation with indepth standards on professional and special programs and services. Programs and services and the pattern of staff development and function within an institution are
focused upon serving the individual needs of residents and should provide for:

(a) Comprehensive diagnosis and evaluation of each resident as a basis for planning programming and management;
(b) Designing and implementing individual habilitation plans (IHPs);
(c) Review, evaluation and revision of the IHPs on a regular basis;
(d) The right of least restrictive environment and/or freedom of movement; and,
(e) Flexibility of services to provide the resident with the opportunity to reach his/her maximum potential.

Proper staff development and training accreditation standards are outlined, from dentistry to volunteer services. Any residential facility not meeting these standards faces the risk of losing federal monies (i.e. medicaid reimbursement).

The major reason for not meeting JCAH and medicaid accreditation standards revolves around the absence of effective training programs for direct-care personnel. Until such time as these preparatory programs are implemented, Ohio's institutions for the mentally retarded and developmentally disabled fail to qualify for federal reimbursement.

Statement of the Problem

The problem of this study is the development, implementation, and measurement of the effectiveness of a training and educational program for direct-care personnel in Ohio's institutions for the mentally
retarded and developmentally disabled. The program will attempt to equip attendant personnel with the basic skills, knowledge and understandings to function adequately within an institutional environment in order that the maximum growth of the individual resident is assured. The central theme of this new program is found in a change in emphasis from one of providing the attendant with the skills to function in a long-term custodial environment to a new program that emphasizes short-term residency; independent functioning of the resident; and, the importance of the attendant's role in the development of resident skills essential for ultimate community placement.

The new training program will attempt to solve four major problems:

(a) It will develop a new civil service classification series (with appropriate job descriptions) for mental retardation workers. This series will replace the existing psychiatric aide classification now employed by each of Ohio's institutions for the mentally retarded and developmentally disabled.

(b) It will develop a more effective training program content consistent with the new classification system (see Appendix C for new classification system).

(c) It will implement the proposed new training programs within one of Ohio's institutions for the mentally retarded.

(d) It will evaluate the efficacy of the new training program. This last step has rarely been attempted in previous programs reported in the literature.

Significance of the Problem

Problems confronting institutional administrators (in Ohio) and their attempts at updating the present ineffective attendant training programs are twofold:
1. The lack of a training program that will reflect a developmental model; one that will not only train mental retardation workers in caring for a given patient, but a program that will focus on the development of knowledge, skills, and understandings which will help meet the habilitative needs of the individual resident, with an emphasis being placed on short-term care. The proposed training program, developed over the past twelve months by the Director of the Department of Mental Health and Mental Retardation's Statewide Task Force on Training (see Appendix D), to accomplish these ends contains specific concepts in the following topical categories:

I. Participation in Institution's Orientation Module.

II. Fundamentals of Mental Retardation.
   a. What is mental retardation.
   b. Classifications and degrees of mental retardation.
   c. Causes of mental retardation.
   d. Terminology within the field of mental retardation.
   e. Incidence and prevalence of mental retardation.
   f. Common fallacies about the mentally retarded.

III. Effective Communications.
   a. Describing behavior.
   b. Reading and writing meaningful reports.
   c. Some important communication skills with residents, peers, and supervisors.
   d. Communicating effectively with parents and guardians; the necessity to be kind, accurate and informative.
IV. Habilitation Programming for the Retarded--Its Importance and Purpose.

a. Habilitation Planning--Importance and Purpose.

b. What should a habilitation plan include.

c. Development of the habilitation plan.

d. Strategies and methodologies for habilitation plans.

1. Introduction to behavioral change techniques within the Individual Habilitation Plan (IHP).

2. Teaching techniques for behavioral change within the IHP.

3. Techniques for maintaining behavioral change within the IHP.

e. Appropriate planning for leisure time activities.

f. Developmental training for the individual resident.

1. Basic-care skills (social and individual).

2. Community living skills.

3. Job-related skills.

4. Observations and recording (behavioral).

V. The Role of the Attendant in Meeting Important Resident Needs.

a. Basic needs.

1. Personal care and hygiene.

2. Feeding.

3. Clothing.

4. Toileting.

b. Health care techniques and skills.

1. Knowledge of human bodily functions.

2. Common diseases and conditions: methods and techniques of observation.

3. Basic first aid training.
c. Use of leisure time.

d. Religious activities.

e. Sex education.

f. Maintaining appropriate environments.
   1. Effect of environment on the resident.
   2. The least restrictive environment.

VI. Senate Bill 336, As Amended (Understanding the Civil and Human Rights of Residents as Reflected in the Ohio Law).

a. The philosophy and intent behind Senate Bill 336.

b. Review of the rules and regulations.

c. Review of the major content areas.
   1. Resident's rights.
   2. Parent/Guardian rights.
   4. Patient abuse.
   5. Resident labor.

VII. The Role of the Attendant in Unit Life Procedures.

a. Maintenance.

b. Nursing care.

c. Dining room.

d. Safety.

e. Restraints, seclusion, resident accountability.

It is felt by the writer, who was Chairman of the Director's Statewide Task Force on Training, that the proposed inservice training program will enhance the maximum development of the direct-care worker and provide for skill training as well as an understanding of modern philosophy governing the care, treatment, and habilitation of the
mentally retarded and developmentally disabled in institutions. Finally, the curriculum illustrated above does not emphasize the long-term care philosophy that has been stressed by institutions in the past, as outlined by Shafter, et. al. (1957) when orientation and training consisted of providing the aspiring attendant with an indoctrination of the institutional grounds, while forgetting the needs of the individuals within its walls. The new curriculum can be viewed in its entirety in Appendix E.

2. A second problem for institutional administrators, when attempting to develop appropriate inservice training programs, is that the resident population of institutions is changing swiftly (Scheerenberger, 1976) and new and existing personnel must be redeployed and their skills reshaped, to reflect the short-term care standards. As Duet, et. al. (1975) points out, "Skill training is not solely limited to the needs of new employees, but often must be designed for experienced personnel who need to cope with technological change or new tasks related to promotion." (p. 162).

Institutional administrators have member staff whose entire emphasis, in the past, has been in working with profoundly and severely mentally retarded individuals. Basic life skills were the only teachings--and then only to those who readily exhibited an ability to learn. This emphasis is documented by Harmatz (1973), Bensberg and Barnett (1966) and Headrick (1963). The new developmental program, already outlined, will require training in all areas depicted above, and will deal with the total development of the mental retardation direct-care worker. The worker will better understand the changes in thinking that have
been taking place within today's institutions; the new laws that have enhanced this new philosophy; and most importantly, they will begin to understand (and hopefully believe) that it is possible to train the mentally retarded person for a life outside the confines of an institutional environment. In short, it is hoped the new program will help attendants realize that mental retardation is not an unchanging or permanent condition. It is, in fact, as Stevens (1964) discusses, "now viewed as a reversible condition". (p. 1).

**Definition of Terms**

The following definitions of relevant terms are provided for clarification within the confines of this study:

**Attendant:** An individual responsible for direct-care of the mentally retarded resident on a day-to-day, hour-to-hour basis. Synonyms for attendant are: psychiatric aide; mental retardation aide; mental retardation worker; ward personnel; and, direct-care personnel. Because of their common usage in the literature, all terms will be utilized interchangeably within the parameters of this study.

**Department of MH/MR executive orders:** Department of Mental Health and Mental Retardation Executive Orders (Series G), are orders which outline Departmental policies on the following issues: patient abuse; restraint of patients; unusual incidents involving patients; fire prevention and fire prevention standards; interim policies on security and safety; attendant and psychiatric aide training; code of ethics; scientific investigations; and, the Mental Health and Mental Retardation Advisory Council.
**Developmental program**: A program that is concerned with the total development of the individual resident, and consists of enhancing the development of a resident with the skills, knowledge, and attitudes regarded as appropriate and necessary for functioning within society. This program is based upon the philosophy that each individual can be helped to learn skills which will increase his or her potential to function more adequately.

**Habilitation program**: The process by which the staff of an institution assists the resident in acquiring and maintaining those life skills which enable him to cope more effectively with the demands of his own person and of his environment and to raise the level of his physical, mental, social and vocational efficiency. Habilitation includes, but is not limited to, programs of formal, structured education and training.

**Independent functioning**: The ability to successfully accomplish tasks or activities demanded by the general community, including critical survival demands for that community, and typical expectations for specific ages, for example, the ability to hold a respectable position outside the institutional environment.

**Institutional administrator**: The Superintendent or Managing Officer of an institution for the mentally retarded. This is the individual who has direct responsibility for all events taking place within the institution and for the lives of its residents. He or she is the appointing authority for that institution.

**Joint Commission on Accreditation of Hospitals (JCAH)**: JCAH was established to improve, through a national voluntary program of
accreditation, the quality of services provided mentally retarded persons. The accreditation process has two major aspects: (1) setting standards for services; and, (2) determining the degree to which a given service complies with such standards." (JCAH, 1975, p. viii).

**Least restrictive environment:** Providing for optimal training of residents in an environment as free of constraint as possible, within an institutional setting. The philosophy, here, is that this type of environment will enhance the resident's chances of moving toward eventual community placement.

**Medicaid:** "Medicaid is an assistance program designed to provide medical assistance to specified groups of needy individuals." (U.S. Department of HEW, 1974, p. 2). Also known as Title XIX of the Social Security Act.

**Normalization:** "A concept emphasizing that the handicapped person should have the same basic rights as other citizens of the same country and same age. These include, among others, the same access to resources, the same opportunity for economic security, the same right to belong, the same privilege of guardianship, the same access to protection, and the same rights to legal representation." (Leland and Smith, 1974, p. 196).

"On-ward" experience: Working with the mentally retarded on a day-to-day, hour-to-hour basis in the position of attendant.

**Right to treatment:** Right to treatment is defined as the obligation of the State of Ohio to provide opportunities for physical, mental, social, and vocational growth for the retarded, within an institutional environment.
Short-term commitment: Ohio's Senate Bill 336, as amended (1974), designates two types of short-term commitment for the mentally retarded. One, is an emergency order (by the Court) issued pending the outcome of the probable cause hearing; the other is an interim order pending the outcome of the commitment hearing. In no case shall the client be incarcerated with charged and/or convicted criminals.

Unitization: The organization of an institution into effective units, to enhance both the education and training of the mentally retarded. It is the combining of the medical, behavioral, and basic treatment concepts into single units, highly autonomous in functioning, to serve a particular resident population (e.g. the deaf-blind retarded).

Hypotheses

This study undertakes to answer several important hypotheses relative to training programs for direct-care workers, not previously addressed (adequately) in the literature. The pivotal hypotheses which this study will concentrate upon are:

NH1: The control group's mean pre-test knowledge score is equal to the experimental group's mean pre-test knowledge score.

NH2: The control group's mean pre-test performance score is equal to the experimental group's mean pre-test performance score.

NH3: The mean pre-test knowledge score of the experimental group is equal to the mean post test knowledge score of the experimental group.

NH4: The mean pre-test knowledge score of the control group is equal to the mean post test knowledge score of the control group.
NH5: The mean gain in the knowledge score of the experimental group is equal to the mean gain in the knowledge score of the control group.

In order to study these hypotheses a population of newly employed direct-care personnel was selected from Orient State Institute, Orient, Ohio. After the population was identified and had completed the required institutional orientation lectures, it was randomly subdivided into control and experimental groups based upon information supplied in the personal information form. The experimental group received "on-ward" experiences and was enrolled in the mental retardation worker staff development program. The control group received no formal training during the duration of the study but did participate in "on-ward" experiences.

At the onset of the study each participant completed a personal information form, which was utilized to depict differences such as age, sex, marital status, educational background, and past job experiences. Members of each group then completed a pre-test examination comprising all of the concepts covered in the staff development program. This pre-test has been labelled the Ohio Mental Retardation Information Scale (OMRIS). In turn, members of the control and experimental groups had their ward work performance rated by a supervisor or unit chairman utilizing the Ward Worker Performance Inventory (WWPI). Both OMRIS and WWPI scores were recorded on each subject and identified as pre-test data. A sample of the OMRIS and WWPI can be viewed in Appendix F.

The above-outlined five hypotheses (stated in the null form) were selected because of the paucity of literature comparing knowledge,
on-ward experiences and performance of institutional direct-care personnel. Studies such as Prien and Cassell (1973), Prien (1972), Gardner and Giampa (1971) and Shotwell, et. al. (1960) concentrate solely upon measuring and identifying the determinants of aide performance. Others, such as Cochran and Steiner (1966), Panyan and Patterson (1964) and Lash and Otness (1949) research only the development of knowledge through appropriate inservice training of the attendant without relating it to performance or other variables which may be affected by increased knowledge. Finally, other studies such as Butterfield (1968) and Johnson and Ferryman (1969) concentrate upon attitudinal change and development within direct-care personnel; while still others such as Taylor (1964), Cliff, et. al. (1959), and Cottell and Shotwell (1954) attempt to measure the personality of ward personnel. Again, few studies combine more than one variable.

A complete review of the literature on attendants and attendant preparatory programs (see Butterfield, 1967, and Parnicky and Ziegler, 1964) illustrates to this writer that on-ward experiences and knowledge have not been measured adequately, together, in any research to date.
CHAPTER II
REVIEW OF RELATED LITERATURE AND RESEARCH

Role of the Institution: Past and Present

It has been shown, by several authors, Kanner (1964); Baumeister (1970); Flanigan, et. al. (1970); Braginsky and Braginsky (1971); Thompson and Grabowski (1972); Ehlers, et. al. (1973); and, the President's Committee on Mental Retardation (1976), that institutions were initially constructed (from approximately 1845 to 1890) for the care, education and training of the mentally retarded. Wolfensberger (1969) indicates that initially, these institutions were typically small, located in the center of communities, and only served individuals who were "curable". In fact, as Clark (1967) has discussed, "It was believed that 'feeblemindedness' could be cured; and in the late 1880's, the quality and care and training provided was superior to that of many schools today." (p. 2).

This early educational model, which advocated right to treatment of the mentally retarded and their independent functioning within society, was replaced by what Wolfensberger (1969) terms the "pity model", in which the mentally retarded were looked upon as individuals to be protected from society as a whole because of their inability to function independently. As Filler, et. al. (1975) illustrates, "This shift in the concept of deviancy had tremendous ramifications. The new institutions that were founded were located great distances from
communities, enlarged to accommodate more residents, and turned from an emphasis on educational activities to more custodial patterns of treatment." (p. 204).

It soon became apparent, however, that the "pity movement" was to be short-lived. Public attitudes had changed; fostered, at least in part, by the eugenics alarm of the early 1900's. Many citizens now felt that institutions were constructed only to protect society from the propagation of these people. Goddard's (1912) study of The Kallikak Family and Kostir's (1916) study of The Family of Sam Sixty were two examples of the eugenic movement's belief that mental retardation was solely hereditary. Fernald (1912) substantiated Goddard's and Kostir's views and articulated the eugenic movement's belief in the moral defects of the mentally retarded when he wrote:

"...the feebleminded are a parasitic, predatory class, never capable of self-support or managing their own affairs. The great majority ultimately become public charges in some form. They cause unutterable sorrow at home and are a menace and danger to the community. Feebleminded women are almost invariably immoral. We have only begun to understand the importance of feeblemindedness as a factor in the causation of pauperism, crime and other social problems... Every feebleminded person, especially the high grade imbecile, is a potential criminal, needing only the proper environment and opportunity for the development and expression of his criminal tendencies. The unrecognized imbecile is a most dangerous element in the community." (p. 90-91).

In the end, proponents of this viewpoint were successful in accomplishing a changing of the originally stated goals of state institutions from rehabilitation to long-term custodial care and lifetime societal isolation. These changes were reflected by the
institutional preparatory programs, which stressed attendant skill development in the processes associated with care and long-term confinement of residents.

Only recently, "After stagnating for many years and offering primarily custodial services to the retarded, even the largest and most staid institutions are entering a period of very decisive changes in philosophy and practice." (Beck, 1969, p. 83). Rothstein (1971) feels that "finally, efforts are being made to change institutional programs from human warehouses to facilities following rehabilitation concepts." (p. 435).

This change in philosophy is in direct reversal to the established pattern of long-term care and confinement of residents. In actuality, today's most informed thinking, i.e. Leland and Smith (1974); Blatt (1973); Blatt (1970); Gunzberg (1973); Braginsky and Braginsky (1971); Wortis (1971); Blatt and Kaplan (1966); and others, embraces a return to the philosophy of proper education and training of the mentally retarded and developmentally disabled, originally ascribed to in the middle-to-late 1800's. Further, the above mentioned authors plus others such as Hobbs (1975); Conley (1973); Vail (1966); and, Robinson and Robinson (1965) recognize that most mentally retarded individuals can be assisted to function at higher personal, social, and vocational skill levels if supplied with proper training and educational programs and experience. Or, as Bensberg (1974) so aptly phrases it, "it is one of recognizing...the retarded person as a developing person" (p. 29).

Niesen, et. al. (1976) estimates that perhaps as many as 50 percent of those now institutionalized could adjust to community life, and
function independently, if they had proper personal and social skills development, plus sufficient community support systems available. This is a conservative estimate when one considers the number of mildly and moderately retarded still residing in state institutions. Proper habilitation of the mentally retarded is, then, a philosophy that espouses a return to the pattern of proper education and training of the mentally retarded, originally ascribed to when the early institutions were founded.

However, even today the State of Ohio, as is the case with a majority of the states, is utilizing a mental health model for the training of its personnel who provide direct-care to the mentally retarded and developmentally disabled (see Appendix G). Primarily, this is a medical (nursing care) model, which basically treats the individual residents as if they were physically ill. The current medical model is not viable in today's institutions for the mentally retarded--at least not within the State of Ohio, where program personnel are hoping to carry out effective developmental and educational programming.

Ohio's institutions are, then, attempting to rid themselves of what Wolfensberger (1969) terms the operating spirit of 1925. They have begun to reflect this change in philosophy; however, their staff development programs for direct-care personnel are not consistent with their new philosophy.

Attendants and the Importance of Their Role in the Maintenance of the Status Quo or Effecting Change

In the previous section, the philosophy of institutions (past and present) was discussed. It should be noted here, that ward
personnel training programs have exhibited a parallel evolution, and are, only now in the middle 1970's, moving toward actual implementation of programs that emphasize (to the aspiring attendant) short-term commitment of most residents. However, this newly discovered philosophy is slow in taking hold.

Bensberg and Barnett (1966) state that, "Attendant training programs have been in existence at least 100 years. In comparing the early programs with those in use today, a remarkable similarity can be found" (p. 24). This is confirmed by Lash and Otness (1949) when they discuss a program developed in 1896 for Fairbault State School and Hospital. Included in this early training program was: nursing, hygiene, sanitation, and child study. If one compares these program components with those of today (nationwide), remarkable similarities are still easily identifiable.

Bensberg and Barnett (1966) report a study conducted by Dr. Grace Sawyer of Woodard State Hospital in 1959. Dr. Sawyer conducted a survey of attendant training programs in both the United States and Canada. Her survey confirmed the Lash and Otness (1949) contention that basic components are found in nearly all ward attendant training programs. Out of 99 institutions surveyed by Dr. Sawyer, 77 responded. The majority of these programs consisted of: orientation, ward management; nursing procedures; housekeeping; and, discipline.

Harmatz (1973) in his investigation of ward staff behavior points out that, "It appeared that time spent at nonchild related tasks (housekeeping, paperwork, etc.) tended to be more visible to superiors" (p. 554). Further, he mentioned that more than half of the ward
personnel's time was spent away from the children, and that much of the time the attendant did spend with the resident was spent in non-social types of actions. It appears that Headrick (1963) in attempting to evaluate the critical incident technique (the identification of common tasks performed) substantiates Harmatz. Headrick divided attendant activities into eight categories: (a) meals; (b) laundry; (c) housekeeping; (d) personal care; (e) socialization; (f) records; (g) ward management; and, (h) miscellaneous. Shafter (1957) illustrates much of the same program content, and Scheerenberger (1975) indicates that very few programs have changed over the past years--his Central Wisconsin Colony and Training School being one of the few that has.

It is easily discernible that many, if not most, of the attendant training programs of the past have emphasized primarily two common components: ward management and housekeeping. This, the writer feels, constitutes an emphasis on custodial care and long-term commitment and rejects the appropriate emphasis of community-oriented (short-term) programs stressing independent functioning of the resident. Further, after a period of time, ward personnel who remain at an institution become competent in the everyday ward activities, such as grooming, feeding, bathing, etc., but are made to feel inadequate when requested to work with other professionals in areas such as behavior change; habilitation programming; and, other skill development areas. This viewpoint was substantiated by Oudenne (1963) when he found that the direct care of a patient consisted of toileting,
bathing, feeding and dressing and did not include instructional or recreational activities.

Bensberg and Barnett (1966) in their reporting of an earlier study (Barnett and Bensberg, 1962) indicate that they conducted a survey of 428 attendants in 26 institutions in 14 southern states. Their results are distinguishable in the following statement.

"The attendants felt they were doing a good job in the way they handled the residents and in meeting the residents' physical needs. Although they felt that there was too much to be done, they felt they knew how to take care of the housekeeping chores on the ward. Other routine chores such as maintaining the clothing room and sorting and distributing laundry also posed few problems. Most of the attendants mentioned the need for improvement in all areas. They seemed to feel more adequate in ward management and physical care than in other areas" (p. 13).

The "other areas" referred to by Barnett and Bensberg (1962) are the areas such as behavior management; habilitation programming; human relations; responsibilities during contact with parents and/or guardians; understanding human behavior and development; understanding the civil rights of residents; and, perhaps most importantly, a strong understanding of the mentally retarded and developmentally disabled's right to care and treatment. With the increasing awareness of the problems facing the mentally retarded, and the belief, i.e. Bensberg, et. al. (1964); Shafter (1960); and, Cleland (1962), that the aide is the most important person in the life of the resident, new training programs must be developed that better equip the attendant personnel with the abilities to handle the myriad of problems facing him or her each day.
If, however, as Smilovitz (1973) illustrates, "...the attendant or houseparent role is universally described as being of great importance," (p. 21) why then, do we see even our smaller, supposedly modern institutions (in both philosophy and structural design) of today concentrating on only long-term custodial-type training—to the detriment of both the direct-care personnel and the resident (and in conflict with portions of the Ohio Revised Code)? In fact, as Bensberg and Barnett (1966) state, "...it is surprising that so little effort has been made over the past century to change the content of attendant training programs" (p. 24).

Within the parameters of this section of the literature review, the writer has attempted to illustrate one significant point: there really is no change in past and present history of aide training programs. The literature clearly depicts no change—or at least very little significant change. The author of this study readily admits that his search of the most recent literature has revealed some highly innovative training programs, in various stages of development and implementation. These programs, however, are the exception and not the rule. Florida's (1975) state training program for direct-care personnel is one example of a new, innovative staff development approach.

It is important to remember that the attendant personnel spend more time with the resident than any other institutional personnel (professional and/or paraprofessional). Moreover, as Butterfield (1969) stresses, "Attendents are the main executors of institutional programs. They are faced with an incredibly wide array of responsibilities ranging from being a substitute parent, janitor and record-keeper,
to being part nurse, part physical therapist, part psychologist and part educator" (p. 433). This viewpoint is substantiated by Parnicky and Ziegler (1964) who feel that the attendants are the "heart of institutional care and treatment programs" (p. 76). It therefore follows that they must be appropriately and adequately trained for the responsibilities assigned them. As Pearl S. Buck (1950) has written:

"I said that I chose my child's permanent home by finding as the head the sort of person whom I could trust. Today, were I to choose again, I would also go into every cottage and look at the type of attendant there. Were they the hard-faced professional type, the ones who go from institution to institution, callous, cruel, ready to strike a child who does not conform, I would reject the place. For the most important person in an institution, so far as the child is concerned, and therefore so far as the parent is concerned, is not the executive, and not the man or woman in the offices, not even the doctor and the psychologist and the teacher, but the attendant, the person who has the direct care of the child" (p. 55 and 56).

Further, Colarelli and Siegel (1966) in discussing staff development training for attendant personnel add:

". . . Why not apply the same logic as before? If a model will help the patients, perhaps a model will help the aides. Why don't we relate to the aides in the same way that we want them to relate to the patients? Why don't we struggle with them, make them our problem, commit ourselves to them? Maybe they will learn to do the same with their patients" (p. v.).

Review of Programs to Help Effect Change

On October 6, 1975, Dr. Norman J. Niesen, Commissioner of the Ohio Division of Mental Retardation and Developmental Disabilities, mailed a request for staff development materials (see appendix H) on attendant inservice training, to each of the other forty-nine
state's Commissioners. This letter was in response to a direct request from the writer, in order that he might review each state's training programs for direct-care personnel, and determine whether significant progress in aide training programs had been made over the past few years. Dr. Niesen further indicated to each Commissioner that recent developments within the State of Ohio (e.g. Senate Bill 336 and Departmental Executive Orders) dictated that new inservice training programs for personnel working in a direct-care capacity be developed and implemented. He further stressed that immediate compliance with his request for information would assist the State of Ohio, and the Director's Task Force on Training and the Director's Executive Committee (see Appendix I) in the development and maintenance of appropriate standards for the State of Ohio.

Responses to Commissioner Niesen's request were varied (see Appendix J). Thirty-five responses were received in the period of October 1975 through May 1976. This amounts to a 70 percent return. Each response falls into one of four categories:

(a) No Staff Development Programs Available;
(b) Staff Development Programs now under Development;
(c) Fully Developed State Programs; and,
(d) No Response.

Table 1 provides further illustration.

A comprehensive review of each of the thirty-five fully developed state training programs for attendant personnel is not the intent of the present study. However, some time must be spent in outlining the programs which represent the newest intent in direct-care personnel
### Table 1

**Status of Attendant Training Programs: Nationwide**

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<tr>
<th>No Programs</th>
<th>Training Programs Under Development</th>
<th>Fully Developed Programs</th>
<th>No Response</th>
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*Ohio has been counted as one of the responding states.

Preparatory programs. Careful review of the thirty-five state's curriculums identified only four programs that stressed both proper habilitation and treatment of the mentally retarded and developmentally disabled. Those stressing treatment alone were regarded by the author as representing the traditional medical model and not representative of the current philosophy
behind direct-care worker training programs.

Innovative Attendant Training Programs

Four state inservice programs were chosen for review by the writer because they stressed not only basic living and treatment skills but habilitation of the resident. These four programs are: (a) Florida (1975); (b) Michigan (1975); (c) Georgia (1975); and, (d) Louisiana (1975).

Florida

Florida (1975) is in the early stages of a complete reorganization and redirection of its staff development program. Plans are being laid to establish two Retardation Staff Development and Training Institutes and four Satellite Staff Development Centers, in selected areas of the state, in order to build a network of staff training centers that will more adequately meet the staff development needs of community and residential center personnel.

The newly formed institute staff will concentrate on the development of training curricula, instructional materials and teaching aids. One innovative section of its newly planned program is in its "training of the trainers." Another is in its establishment of model training units that will be named Practicum, Observation and Demonstration Sites (PODS Program), for the purpose of pre-service and in-service training programs. This approach, Florida officials feel, will relieve, somewhat, the problem of releasing staff for training, since new staff will be assigned to the specialized staff-client training PODS and will receive their training within the unit. They will receive an orientation and brief classroom training program before placement in the PODS, but once
placed, most training will then be provided by an experienced and well trained cadre of staff responsible for the skill and proficiency training needed, as well as the additional responsibility of developing positive attitudes toward habilitation and training of clients.

Florida is only now in the beginning stages of its reorganizational process. The respondents indicated to the writer that they would need at least another six months before they had completed their program. Florida's final staff development program will incorporate both basic daily living skills and habilitation programming. Emphasis in the final program will be on the habilitative aspects of resident training. This will mean a complete revision of its past training emphasis. The new training curriculum, once revised, will reflect a competency-based model; one which will allow the direct-care worker to demonstrate his or her competencies at given timeframes within the training process.

Michigan

Michigan (1975) also indicated that its curricula was in the final stages of preparation. Its new program, based on past problems, will reflect a new training emphasis. Rather than viewing the mentally retarded institutionalized resident as a primary target of education, prior to placement, direct-care personnel are seen as equally important recipients of training. Michigan's experience is summed up by Rosen (1975) when he states, "This experience has convinced us that as important as many components of sound deinstitutional programs are, none is more critical to success than preparing those persons in residence and direct care roles" (prologue).
Michigan's new curriculum is centered within its publication entitled, Resident Manager Training: A Curriculum Model for Educating Foster Parents and Group Home Personnel. It is comparable to the Ohio program outlined on pages 7 through 10 and includes the following points of emphasis:

(a) Orientation to mental retardation.
(b) Community placement.
(c) Fire and safety considerations.
(d) Maintaining health environments, providing emergency care.
(e) Elements to be considered in programming.
(f) Influencing behavior.
(g) Educational considerations.
(h) Relationships with natural families.
(i) Leisure time--recreations.
(j) Administrative responsibilities.
(k) Thoughts on sexuality.
(l) Vocational considerations.

The curriculum outlines above is a combination of habilitation and treatment programs. It reflects an emphasis in assisting retarded individuals in preparing for their entry into "normal" society. Again, adequate preparation of residents (before community placement) is its central feature.

Georgia

On January 7, 1975, the Director of the Georgia Retardation Center (GRC) approved a proposal for a new staff development system. This systematic approach to staff development activities was approved because
it offered a logical decision-making structure that enabled the GRC to make choices which would achieve training and develop goals efficiently and effectively.

GRC then, has begun the first step in designing a comprehensive staff development system. In June of 1975, a Task Force of Manpower Development and Personnel staff was trained to analyze jobs objectively, in order to generate tasks and training content necessary to yield the skills and knowledge required to perform a specific job. Utilizing **Functional Job Analysis**, the Task Force focuses on tasks, rather than jobs as the fundamental unit of work, and continually relates tasks to performance standards. Each task statement includes a description of the activities involved in the task, expected results, performance standards, training content, and measures of complexity, as well as general educational development; all relating to the requirements of the particular task in question. This information is then utilized to assess the complexity of the task; determine worker qualifications; determine on-the-job training requirements; provide accurate instructions to workers; and, develop criteria for assessing satisfactory performance.

The State of Georgia also places an emphasis in "training the trainers", as well as independent functioning (leading to community placement) of the resident. Although all materials have not yet been fully developed, Georgia supplied this writer with the following instructional units (not unlike those depicted on pages 7 through 10):

(a) Orientation.

(b) Basic training for attendant level staff.

(c) Dying, death and grief seminar.
(d) Human sexuality and the retarded.
(e) Dealing with aggressive combative students.

Louisiana

Inservice training in Louisiana (1975) is divided into two non-overlapping components:

(a) Statewide inservice training; and,
(b) Facility (institutional)-wide inservice training.

The statewide inservice training program is administered by the Louisiana State Office of Mental Health and Mental Retardation and is responsible for all interfacility training and coordination. Facility-wide inservice training programs are conducted by each facility and are responsible for all inservice training and coordination within individual facilities.

Louisiana's (1975) inservice training programs (both statewide and facility-wide) show a particular strength in evaluation. The evaluation process consists of: (a) workshop evaluation; (b) speaker evaluation; and, (c) course content evaluation. Obviously step 3 allows the trainee to evaluate the worth of the inservice training program.

Several training programs were outlined (e.g. Attendant II; Cottage Parent I, II, III; and, Physical Therapist Assistant's Aide). All contained at least the following within their particular format:

(a) Handling behavior problems.
(b) Ethics and responsibilities on the job.
(c) Techniques of training.
(d) Working effectively with the supervisor.
(e) Common medical problems.
(f) Medication and first aid.
(g) Causes of mental retardation.

Other areas were also listed, common to each category; however, the above outline depicts both basic living skill training and resident programming. The strength, however, in both statewide and facility-wide training comes in its evaluative process--uncommon to many state programs (i.e. New Jersey, 1959; Kansas, 1974; and, North Carolina, 1975).

Finally, other state programs having merit should be mentioned, because of their grasp of the new concepts of habilitative treatment for the mentally retarded. These are:

(a) Colorado (1974).
(b) Arkansas (1975).
(c) Pennsylvania (1975).

Each of the above is approaching the point of merging basic skill training with the process of habilitation programming, felt by this writer to be necessary in the life of the resident--if an improved quality of life in the institution and/or community placement is the final, most desired goal.
The procedural process of this investigation was intricate and time-consuming. Essentially, there were three major components involved in developing the Worker I preparatory program. These components were:

a. The Director's Task Force on the Development of Training Programs (Appendix I);
b. The Expert Panel (Appendix M); and,
c. The author of this study.

Each group member, or individual, had specific tasks which would eventually lead to the development and implementation of the new staff development program for Worker I personnel.

The Director's Task Force

The responsibilities of the Director's Statewide Task Force on Training were threefold:

a. Assisting in the selection of the content of the staff development program for the direct-care personnel;
b. Assisting in the development of a particular learning module; and,
c. Developing the final training program after outside evaluation.
Members of the Director's Task Force were appointed to represent a wide array of field professionals (e.g. nurses; unit managers; institutional program directors, etc.). This type of committee received appointment in order to assure that a comprehensive program was developed for direct-care personnel.

Once the committee members had selected the content of the training program, they were then broken into several sub-groups that developed the first rough draft of a particular training module. For example, the nurses were concerned with the development of most of Module IV, which consists of basic health care and treatment of the resident. On the other hand, the institutional program directors and unit managers were an integral part of the development of the modules on Habilitation Programming and the Role of the Attendant in Unit Life Procedures.

The third responsibility of the Director's Task Force on Training was in the development of the final training program after the rough draft received Expert Panel Evaluation. This task came at a later date in the process of the development of the Worker I program and consisted of making the necessary revisions (additions and deletions) as recommended by the Expert Panel.

The Expert Panel

The Expert Panel was appointed from nationally recognized authorities in the field of mental retardation. The panel represented the many fields of expertise needed for the total development of a comprehensive staff development program for direct-care personnel. Members of this panel were selected for a variety of reasons. One, of course, was their background experiences in the field of mental retardation. A
second was their close geographical location to the author's study which allowed them to participate more fully than if they had been located at various points throughout the nation. A third, and perhaps the most important reason for their selection was the specific past experiences that each member brought to the panel. These experiences included: expertise in development and implementation of right to treatment standards; insights into the new process of habilitation services to the mentally retarded and developmentally disabled; past experiences in the development of the first standards for classification and treatment of the mentally retarded and developmentally disabled which resulted in one of the American Association on Mental Deficiency's first publications entitled Manual on Terminology and Classification in Mental Retardation (1964); and, finally, one member of the Expert Panel brought with him the unquestioned credential of having published one of only two literature reviews on attendants that exists today (Parnicky, et. al. 1964).

Members of the Expert Panel were:

a. Dr. Robert Carl, Superintendent, Columbus State Institute, Columbus, Ohio.

b. Dr. Roger Gove, State Medical Consultant, Department of Mental Health and Mental Retardation, Columbus, Ohio.

c. Mr. Michael Kindred, J.D. Associate Dean, The Ohio State University School of Law, Columbus, Ohio.

d. Dr. Maxine Mays, Assistant Commissioner, Office of Habilitation Services, Division of Mental Retardation and Developmental Disabilities, Columbus, Ohio.

e. Dr. Norman Niesen, Commissioner, Division of Mental Retardation and Developmental Disabilities, Columbus, Ohio.

f. Dr. Joseph Parnicky, Professor, Nisonger Center, The Ohio State University, Columbus, Ohio.
g. Dr. Alfred Soforenko, Superintendent, Orient State Institute, Orient, Ohio.

The responsibilities of the Expert Panel were in the rating of the proposed concepts (developed in rough draft form by the Director's Task Force on Training) that each direct-care worker was expected to learn. The Expert Panel, in essence, was responsible for the final content validity of the staff development program. The panel's evaluative efforts (see Appendix K) consisted of rating all concepts included in the rough draft. This evaluation was undertaken on a 4-point rating scale with all concepts rated from not important through highly important. All concepts rated either "highly important" or "important" were retained for inclusion in the final direct-care preparatory program.

The Author

The development of the direct-care training program discussed in the previous two sections took approximately one year. During that period of time the author of this study had the following responsibilities:

a. Coordination of the Director's Statewide Task Force on Training. This included setting up weekly meetings with the Task Force and monitoring the progress of the module development.

b. Conducting a nationwide survey of direct-care training programs and compiling the results of that survey. As training programs were received, the author reviewed them and presented each program to the Director's Task Force. If parts of a certain state's program were found to be applicable for use within Ohio's program, they underwent
further review by the specific sub-group that it related to.

c. The writing of modules on introduction to mental retardation; the aggressive resident, and S.B. 336. The author was a member of the particular sub-group that decided on the content of the above-mentioned modules and then had the responsibility for completion of the rough draft copy.

d. Development of a new civil service classification based on the training program's content. The results of this effort can be viewed in appendix C. It should be stressed at this time that in order for curriculum to become effective, it must have an understandable career ladder for an employee to follow. In other words, an employee must know what he or she will be accomplishing by successfully completing this training program. Will they receive promotions, raises in pay, etc.?

e. "Selling" the new direct-care curriculum to labor representatives. The same discussion used in point "d" above can be added here. Labor unions are interested in what a new program will do for their members. It was the author's responsibility to outline the program's importance, features, and sell the unions on the applicability of the new program to the career of any given union member.

f. Selection of the Expert Panel. It was the author's responsibility to select the Expert Panel that would evaluate
the content of the Worker I training program. Appendix M exhibits the author's letters to each eventual panel member and their response.

g. Development of a career ladder for direct-care personnel. Development of an appropriate career ladder parallels that of the civil service classification and the training program. Although the intent of this study was the development and measurement of the Worker I training program, a future career ladder for direct-care personnel in its simplest form is outlined below.
h. Monitoring the progress of the training program as it was undergoing testing. The author received daily updates during the training cycle. Within this area, the author met and planned with members of the Orient State Institute Staff Development Section and planned the scheduling for each module. Scheduling included release-time for each direct-care worker participating in the program, selection of training site (i.e. medical building, classroom, etc.), and scheduling of the pre and post test examinations.

i. The measurement of the final effectiveness of the Worker I training program. This included the actual analysis of variance conducted on the pre and post test scores of each group and will be discussed in depth in a later section.

Finally, a timeline was developed by the author that outlined the entire process of the curriculum development. The thirteen (13) procedures that follow highlight not only the timelines that the various groups of individuals adhered to, but also the complexity of the curriculum development process. It is felt by the author that inclusion of these thirteen steps will illustrate to various other professional groups, the total involvement that one must go through to develop, implement and evaluate an effective training program. The procedures for development of the preparatory program with timelines for completion are as follows:
a. By September 1, 1975, selection of the Director's State­wide Task Force on Training was completed.

b. By December 1, 1975, existing training programs, both in Ohio and Nationwide, were surveyed by the writer.

c. By January 1, 1976, the Director's Task Force on Development of Training Programs constructed an outline of Worker I modules they felt were needed for inclusion in a comprehensive aide training program.

d. By February 1, 1976, these "content-categories" were circulated to the Commissioner of Mental Retardation and Developmental Disabilities; the Task Force's Executive Committee (see Appendix I); and, the Assistant Commissioner's of Mental Retardation and Developmental Disabilities for their evaluation, relative to the importance of the content within each category. Moreover, each above-named individual was invited to include additional categories, which they felt were important to the total development of the attendant.

e. By February 15, 1976, all completed evaluations were reviewed by the Director's Task Force on Training.

f. By February 29, 1976, a new master list, including all content categories was developed.

g. By February 29, 1976, an Expert Panel was appointed (see Appendix M), from nationally recognized authorities in the field of mental retardation. This panel established the final content validity of the Worker I
training program. The Expert Panel evaluation was undertaken on a 4-point rating scale with topics falling into the categories of Highly Important and Important retained for inclusion in the eventual Worker I curriculum. (See Appendix K).

h. By March 21, 1976, the Director's Task Force on Training had fully developed the Worker I Curriculum based upon the content categories validated by the Expert Panel.

i. By April 5, 1976, the final training curriculum for Worker I personnel was assembled and presented to the Superintendent of Orient State Institute, Orient, Ohio--the planned site for the curriculum testing.

j. By April 10, 1976, the Director's Task Force on Training, under the guidance of this writer, developed a pre and post competency test based upon the content of the Worker I training program (earlier evaluated by the Expert Panel) which was named the Ohio Mental Retardation Information Scale (OMRIS). (See Appendix F).

k. By April 10, 1976, the writer developed a Ward Worker Performance Inventory (WWPI), which measures gains in worker performance. The WWPI was evaluated by at least five (5) institutional program directors or assistant superintendents in charge of program, as a future evaluative instrument. There was none at this time. (See Appendix F).
1. During the week of May 7-21, 1976, the training program will be tested at Orient State Institute, Orient, Ohio. This testing determined whether or not the Worker I curriculum would be adopted by the Department of Mental Health and Mental Retardation for use in its institutions for the mentally retarded and developmentally disabled.

m. On or about May 21-28, 1976, final post test information was compiled on those individuals participating in the curriculum training sessions; and, on the control group receiving only the on-ward experiences mentioned earlier.

As a result of adhering to strict timelines and job responsibilities, (outlined in earlier sections) Ohio's new curriculum for the Mental Retardation Worker I emerged. The curriculum is composed of six modules in which each new direct-care worker is expected to successfully participate during a three week time span.

Ohio's Proposed New Curriculum

Ohio's proposed Mental Retardation Worker I Training Program is separated into six competency-based modules. Each module's content is outlined below. Again, the final curriculum resulted from The Expert Panel's Evaluations of the initial rough draft submitted by the Director's Statewide Task Force on Training. This evaluation can be viewed in its entirety in Appendix K; while the entire curriculum is exhibited in Appendix E.
The Worker I Curriculum

MODULE I

A. Subject: Fundamentals of Mental Retardation (no prerequisites).

B. Purpose: To familiarize the Worker I Trainee with the basic fundamentals of Mental Retardation.

C. Readings/Resource Materials: This is essentially a reading module with appropriate discussion time for each topic. Some media are utilized. Readings and discussions concentrate on the following topical categories:

1. What is mental retardation?
2. Classifications and degrees of mental retardation.
3. Causes of mental retardation.
4. Terminology in the field of mental retardation.
5. The incidence and prevalence of mental retardation.
6. Common fallacies concerning the mentally retarded.

D. Media Supplement(s): The following films are utilized as part of the training for Module I:

1. Somebody's Waiting -- 25 minutes. Senoma State Hospital, Senoma, California.

2. The Nature of Mental Retardation -- 25 minutes. Kansas Audiovisual Center (Film Rental Service), 746 Massachusetts Street, Lawrence, Kansas.

MODULE II

A. Subject: Senate Bill 336, as amended; or, Understanding the Civil and Human Rights of Residents as Reflected in Ohio Law. (pre-requisite -- Module I).
B. Purpose: To familiarize the Worker I Trainee with the basic concepts behind Senate Bill 336 (Ohio's Right to Treatment Law).

C. Readings/Resource Materials: This is essentially a reading module with appropriate discussion time for each topic. Readings and discussions focus on the following topical categories:
   1. Introduction to Senate Bill 336, as amended.
   2. The civil rights of residents under Senate Bill 336.
   3. Voluntary versus involuntary admissions.
   5. The Individual Habilitation Plan.

D. Media Supplement(s): None.

MODULE III

A. Subject: Habilitation Programming for the Retarded--Its Importance and Purpose (Prerequisites--Modules I and II).

B. Purpose: The purpose of Module III is that of presenting a learning program in habilitation programming in which the Worker I Trainee proceeds at his/her own rate of speed. The content surrounding Module III was evolved with the idea that it is the most important concept the Worker I Trainee must understand.

C. Readings/Resource Materials: The format of Module III is that of programmed instruction in the form of nine (9) distinct learning experiences concerning proper habilitation programming of the mentally retarded. Each learning experience is listed below:
   1. Developing an individual habilitation plan (IHP).
   2. The resident's strengths and weaknesses.
   3. Strategies and methodologies for IHP's.
4. Maintaining behavioral change techniques within the IHP.
5. Appropriate planning for leisure time activities.
6. Developmental training of the individual.
7. Community living skills.
8. Job-related skills.

D. Media Supplement(s): The following films are utilized in conjunction with Module III:
1. **Genesis** -- 25 minutes. Hallmark Films and Recordings, Inc., 1511 Eastworth Avenue, Baltimore, Maryland.
2. **Ask for Little Things** -- 20 minutes. Hallmark Films and Recordings, Inc., 1511 Eastworth Avenue, Baltimore, Maryland.
3. **I'll Promise You Tomorrow** -- 20 minutes. Hallmark Films and Recordings, Inc., 1511 Eastworth Avenue, Baltimore, Maryland.

**MODULE IV**

A. Subject: Treatment, Safety and Health. Procedures in Resident Care (Prerequisites -- Modules I, II, and III).

B. Purpose: To familiarize the Worker I Trainee with the role of the direct-care worker in providing for the basic care, health and safety of the resident.

C. Readings/Resource Materials: Module IV is separated into five distinct phases. Lectures, discussions and many demonstrations comprise each phase. The five phases are:
1. **Treatments.** Demonstrations and practical application in:
   a. Temperature, pulse and respiration (TPR).
b. Blood pressure (BP).
c. Enema -- suppository.
d. Ointments.
e. Drops (eyes, ears, nose).
f. Ace bandages.
g. Compresses (hot and cold).

2. **Personal Care of Residents.**
   
a. Types of bathing.
b. Nail care procedures.
c. Shampooing of hair.
d. Mouth care.
e. Shaving.
f. Toileting.
g. Clothing care.
h. Oral hygiene.
i. Mealtime procedures.

3. **Observing, Reporting, Preventing and Treating of Unusual Bodily Conditions.**
   
a. Signs and symptoms of disease.
b. The Heimlich Maneuver.
c. Diabetes-mellitus.
d. Epilepsy.
e. Positioning of residents.

4. **Prevention and Treatment of Contagious Conditions.**
   
a. Amebiasis or amebic dysentery.
b. Viral hepatitis (both serum and infectious).
c. Pediculosis.

5. Care, Treatment and Proper Handling of the Aggressive Resident.
   b. Crises intervention.
   c. Hints for your own protection.
   d. Things which you can do to reduce the need for behavioral restraint.
   e. Suggestions for holding or handling resistive or disturbed residents.

D. Media Supplement(s): All phases are included in the following breakdown:

1. **Trainex Series on Basic Health Care** (one series of each of the distinct phases). Trainex: Harris-Tuchmann Productions, Inc., 751 Highland Avenue, Hollywood, California.

2. **One Step Ahead** -- 28 minutes. Motorola Teleprograms, Inc., 4825 North Scott Street (Suite 23), Schiller Park, Illinois.

3. **Feeding: Normal and Abnormal Processes** -- 30 minutes.
   Fairbault State Hospital, Indianapolis, Indiana.

MODULE V

A. Subject: Effective Communications (Prerequisites -- Modules I, II, III, and IV).

B. Purpose: To familiarize the Worker I Trainee with effective communications with residents, peers, and supervisors.

C. Readings/Resource Materials: This is essentially a reading module with appropriate discussion time for each topic. Readings and discussions concentrate on the following topical categories:
1. A communications overview.
2. Kron -- "Communications in Nursing".
4. Thorne -- "Understanding the Mentally Retarded".
5. Levels of listening.

D. Media Supplement(s): The following films are utilized as part of the Module V training:


MODULE VI
A. Subject: The Role of the Attendant in Unit Life Procedures (Pre-requisites -- Modules I, II, III, IV, and V).
B. Purpose: To familiarize the Worker I Trainee with the concepts of "active treatment," "least restrictive setting," and "the IHP," as they are applicable to Unit Life Procedures.
C. Readings/Resource Materials: This module is based on simulation exercises, and discussion of those exercises. Situations include the following:

1. The right of freedom of choice within the individual's capacity to make a decision.
2. The right to live in the least restrictive, individually appropriate environment.

3. The right of the institutionalized citizen to express himself/herself through phone conversation and in written form.

4. The right of resident or guardian to refuse to participate in any phase of habilitation programming.

5. The right of protection against exploitation, demeaning treatment, or abuse.

6. The right to participate in a comprehensive set of habilitative programs appropriate to his/her level of intellectual functioning.

D. Media Supplement(s): None.

In summary, upon successful completion of the program outlined in the six modules above, each Worker I will receive a certificate of achievement (see Appendix L). Moreover, once the State Civil Service System has absorbed the Worker I classification, these individuals hopefully will be given priority status with respect to transfers, promotions, pay increases, etc. As noted earlier, the Worker I Training Program is an employee's initial step into a career in programming for the mentally retarded and developmentally disabled. What hopefully follows is a career ladder lattice (outlined earlier) which is appealing to employees and which will result in less turnover among direct-care workers.
Methodology

Methodology guiding the design of this study can be separated into three topical categories:

(a) Selection and development of the measuring instruments;
(b) Identification and selection of the experimental and control group populations; and,
(c) Treatment of the data.

Selection and Development of the Measuring Instruments

In addition to the Ohio Mental Retardation Information Scale (OMRIS) developed to test the individual's knowledge of mental retardation and developmental disabilities and the personal information form (which will be utilized to delineate such items as age; sex; marital status; educational background; work experience, etc.), one further instrument was utilized within the parameters of this study. The Ward Worker Performance Inventory (WWPI) will be constructed to measure gains (or losses) in the performance of both the experimental and control groups. Once administered at the outset of the study, three weeks will precede the second application of this instrument.

After an exhaustive review of the literature, no instrument was identified that evaluated worker performance qualitatively. The literature did reveal various attempts to evaluate direct-care worker performance in a quantitative vein, i.e. Prien, et. al. (1973); Gardner, et. al. (1971); and, Amble, et. al. (1971); particularly as it related to expenditure of time in various ward activities. The assumption of the above-mentioned authors is simply that increased expenditure of time in certain activities indicated an improved attendant performance.
Skills relating to performance and knowledge of the field of mental retardation and developmental disabilities did not enter into their respective investigations.

Development of the Ward Worker Performance Inventory consisted of a series of meetings where criteria were supplied by the various educational program directors and/or assistant superintendents in Ohio. After review and selection of criteria was completed, a twenty point scale was developed (and underwent final evaluation) by a special committee of institutional program directors and/or assistant superintendents in charge of program. A 4-point scale, much the same as the Expert Panel utilized, was used in the final evaluation of the criteria.

Identification and Selection of the Experimental and Control Groups

Permission was granted by Dr. Alfred Soforenko, Superintendent, Orient State Institute, Orient, Ohio, to test the Worker I curriculum within the boundaries of the institutional setting under his supervision. Moreover, the large amount of attendants requiring this training made it possible for the writer to select his experimental and control populations in a randomized manner utilizing a table of random numbers which allows the experimenter to assign a group(s) of individuals to the study without influencing the assignment of the sample either directly or indirectly. The selection of the subjects is guided by a sequence of numbers in a table which has been subjected to tests of randomness. Ray (1960) suggests that:
"Since the sequence of random numbers is independent of the experimenter's personal judgment and characteristics of his subjects, the numbers are an invaluable aid to research." (p. 45).

After selection, subjects in the experimental and control groups were formed into what they were made to understand as "groups one and two". The Orient State Institute staff conveyed to the experimental group that they were "group one" and would be going through staff development training first. "Group two (in actuality the control group) understood that it would undertake training as soon as group one was finished. The reason given for splitting into two groups (after administration of the pre-test instruments) was that the size of this particular class was too large to train together. Both groups also understood that this training was required before they could become "full-fledged" direct-care workers. They were not told that they were taking part in a new training program and the fact that all training was given by Orient staff allayed any suspicions they might have, since all other attendants before them had received training from the same staff. Orient State Institute conducts staff development training for its attendants every two weeks. Approximately fifty to seventy individuals are involved in each training cycle. A target date for testing the Worker I program was May 7, 1976. Figure 1 outlines the basic process for completion of this training program.

Treatment of the Data

In addition to the personal information form, pre and post-test scores will be recorded on each subject in the experimental and control groups on:
Figure 1

*The control group has undertaken a staff development program of its own, now that this study is completed.
(a) The Ward Worker Performance Inventory, and
(b) The Ohio Mental Retardation Information Scale.

Mean scores were computed on the pre and post test data on each instrument, for both the experimental and control groups. The pre and post means for each group were compared and the differences in mean scores were tested utilizing analysis of variance (ANOVA). Meter, et. al. (1974) states that:

"Analysis of variance is a versatile statistical tool for studying the relation between a dependent variable and one or more independent variables. It does not require making assumptions about the nature of the statistical relation, nor does it require that the independent variables are quantitative." (p. 419).

Neter's viewpoint is substantiated by Kennedy (1976), Wonnacott, et. al. (1972), and Kerlinger (1964) who has described ANOVA as, "... not just a statistical method. It is an approach and a way of thinking." (p. 187).

Finally, analysis of variance techniques were selected by the writer for the following five reasons:

(a) Analysis of variance can generally be utilized when data resulting from an experiment are interval.

(b) Analysis of variance is appropriate when a test of statistical significance is needed between two or more treatment groups.

(c) Analysis of variance compares different factor level effects (a factor is an independent variable under investigation).
(d) Analysis of variance is able to ascertain the most significant factor level.

(e) Finally, analysis of variance determines whether or not the different factors interact, which factors are the key ones, and which factor combinations are significant.
CHAPTER IV
RESULTS AND DISCUSSION

Analysis of the Data

Both experimental and control groups were given the test of knowledge (OMRIS) and performance (WWPI) in order to measure initial pre-test abilities. The pre-tests were then compared to the post test results to measure any improvement or loss. The groups differed in the pre-test results, both in knowledge and performance. The experimental knowledge mean score was 135.15, while the control group's knowledge mean score was 158.73. The performance mean scores showed the experimental group with a mean of 7.77 and the control group with a mean of 8.66.

The first statistical endeavor was to determine whether there existed a significant difference in the initial ability (pre-test condition) of the two groups. The statistical analysis which follows assumes that the test scores are normally distributed (in both groups) and the variances are equal. The following hypothesis was tested with respect to the knowledge pre-test condition.

H0: The control groups' mean pre-test knowledge score is equal to the experimental groups' mean pre-test knowledge score.

The results are illustrated in Table 2 and they suggest that there is no statistically significant difference in the pre-test ability of the
two groups. Consequently, null hypothesis one could not be rejected.

Table 2
Measure of Experimental and Control Groups Abilities in Knowledge

<table>
<thead>
<tr>
<th>Groups</th>
<th>Mean Knowledge Score</th>
<th>F-Value</th>
<th>Prob &gt; F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>153.15</td>
<td>0.63995</td>
<td>0.4278</td>
</tr>
<tr>
<td>(N=26)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>158.73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(N=22)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The identical statistical procedure was conducted for null hypothesis two in order to determine pre-test ability in performance of the experimental and control groups. Null hypothesis two reads as follows:

NH2: The control group's mean pre-test performance score is equal to the experimental group's mean pre-test performance score.

Results are displayed in Table 3 and provide evidence that the control group's initial (pre-test) performance score is statistically significantly greater than the experimental group's initial performance score.

Table 3
Mean Performance Scores of Experimental and Control Groups

<table>
<thead>
<tr>
<th>Groups</th>
<th>Mean Performance Score</th>
<th>F-Value</th>
<th>Prob &gt; F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>7.77</td>
<td>5.41605</td>
<td>0.0244</td>
</tr>
<tr>
<td>(N=26)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>8.66</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(N=22)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The control group's initial performance score is significant at \( \alpha = .05 \), suggesting that null hypothesis two must be rejected. This result is somewhat unfortunate, since it strongly suggests that a comparison of pre and post test scores cannot be undertaken. In short, it would be difficult to determine if the post test position was due to some treatment, or simply a difference in initial abilities. Since null hypothesis two and its pre-performance scores failed this test of homogeneity, further analysis of the performance variable was not undertaken. However, the author feels it is appropriate to make comparisons of both the experimental and control group's pre and post performance scores. The experimental group's pre-performance mean score was 7.77 while the control group's mean performance score was 8.66. (see Table 3). This level of significance \( \alpha = .05 \) suggests that it would be difficult to determine whether or not the group's post test scores were due to some treatment (the staff development program), or simply some difference in the performance abilities of the groups. Since the level of significance was at \( \alpha = .05 \), however, inferences could be made regarding the performance variable and its relation to Ohio's new staff development program for direct-care personnel (at the Worker I level).

Individual performance scores for each group (pre and post) follow in Table 4. Again, these scores are the individual average scores on the 20-point Ward Worker Performance Inventory (WWPI). Names of each trainee have been omitted.
## Table 4

Individual Performance Scores

<table>
<thead>
<tr>
<th>Name</th>
<th>Control</th>
<th>Experimental</th>
<th>Control</th>
<th>Experimental</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7.70</td>
<td>9.30</td>
<td>7.50</td>
<td>8.60</td>
</tr>
<tr>
<td>2</td>
<td>7.70</td>
<td>7.35</td>
<td>7.50</td>
<td>8.60</td>
</tr>
<tr>
<td>3</td>
<td>6.75</td>
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<td>6.35</td>
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<td>5</td>
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<td>4.65</td>
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<td>8.55</td>
<td>9.10</td>
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<td>7</td>
<td>8.70</td>
<td>9.66</td>
<td>8.30</td>
<td>9.50</td>
</tr>
<tr>
<td>8</td>
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<td>9</td>
<td>11.05</td>
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<td>10.60</td>
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<td>6.25</td>
<td>9.45</td>
<td>4.35</td>
<td>10.40</td>
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<tr>
<td>26</td>
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<td>4.68</td>
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<td>2.95</td>
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<tr>
<td>27</td>
<td></td>
<td>8.90</td>
<td></td>
<td>8.00</td>
</tr>
</tbody>
</table>

Mean Scores: 8.66, 7.77, 8.34, 8.06
Table 5 exhibits the results of the experimental and control groups post-performance evaluation. The experimental group increased from a pre-performance evaluation of 7.77 to a post-performance evaluation of 8.66. However, the control group decreased from an initial performance evaluation of 8.66 to a post-performance evaluation of 8.34. One possible interpretation of these results is that the staff development program helped the experimental group improve its performance ratings, while lack of this program showed a decrease in the performance of the control group.

Table 5

Comparison of Pre and Post Test Performance Evaluations--Mean Scores

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre-Performance Mean Score</th>
<th>Post-Performance Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>7.77</td>
<td>8.06</td>
</tr>
<tr>
<td>(N=26)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>8.66</td>
<td>8.34</td>
</tr>
<tr>
<td>(N=22)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Inspection of demographic characteristics indicated that both groups were homogeneous in that respect, providing evidence that differences in performance ability could not be attributed to these factors. These comparisons are shown in Table 6. It should be noted, here, that demographic variables are used to determine similarities and/or differences between groups, i.e. they are looked at to insure the two groups are truly similar in obvious characteristics (e.g. age, sex, etc.).
Table 6
Comparison of Experimental and Control Group Demographic Characteristics

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
<th>F-Value*</th>
<th>Prob &gt; F**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>0.05185</td>
<td>0.8209</td>
</tr>
<tr>
<td>Age</td>
<td>0.59887</td>
<td>0.4429</td>
</tr>
<tr>
<td>Marital Status</td>
<td>0.73081</td>
<td>0.3970</td>
</tr>
<tr>
<td>Educational Background</td>
<td>0.02375</td>
<td>0.8782</td>
</tr>
<tr>
<td>Job Experience</td>
<td>1.84197</td>
<td>0.1812</td>
</tr>
</tbody>
</table>

*F-Value - The F-Value is a measure of how similar or different groups are. For example, a high F-Value suggests that the groups are different, a low F-value provides evidence that groups are similar.

**Prob > F - This is the probability that the two groups were drawn from the same population. If the Prob > F is small, for example, then it suggests that the two groups were drawn from the same population.

At this point in the investigation, further analysis was undertaken on inter and intra group gains in knowledge. These were measured by comparing the mean pre and post test scores of the experimental and control groups. The experimental group's mean scores was 153.15 and mean post test score was 184.61. To determine if this represented a statistically significant improvement, null hypothesis three was tested. It reads:

NH3: The mean pre-test score of the experimental group is equal to the mean post test score of the experimental group.

The results are shown in Table 7 and provide evidence that the experimental group's improvement is significant at $\alpha = .01$. This does
illustrate that significant improvement was made and that null hypothesis three should be rejected.

Table 7
Comparison of Pre/Post Mean Test Scores: Experimental Group

<table>
<thead>
<tr>
<th>Experimental Group</th>
<th>Mean Scores</th>
<th>F-Value</th>
<th>Prob &gt; F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Test</td>
<td>153.15</td>
<td>25.05536</td>
<td>0.0001</td>
</tr>
<tr>
<td>(N=26)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-Test</td>
<td>184.61</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(N=26)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An analogous procedure was followed for the control group. More specifically, null hypothesis four was tested. It is shown below:

NH4: The mean pre-test score of the control group is equal to the mean post-test score of the control group.

The statistical results are summarized in Table 8 and they showed that the control group (as was true with the experimental group) experienced a statistically significant improvement ($\alpha = .05$) between pre and post mean scores in knowledge. This data supports the rejection of null hypothesis four.

Table 8
Comparison of Pre/Post Mean Test Scores: Control Group

<table>
<thead>
<tr>
<th>Control Group</th>
<th>Mean Scores</th>
<th>F-Value</th>
<th>Prob &gt; F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Test</td>
<td>158.73</td>
<td>4.98897</td>
<td>0.0309</td>
</tr>
<tr>
<td>(N=22)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-Test</td>
<td>170.59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(N=22)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
An interesting hypothesis is whether the improvement of the experimental group (153.15 to 134.61) in knowledge (defined as the change in mean score between pre and post tests) is significantly greater than the control group's improvement (158.73 to 170.59). If so, it would provide evidence that the difference in improvement would be due to the staff development program. More specifically, null hypothesis five was tested and reads as follows:

NH5: The mean gain in the knowledge score of the experimental group is equal to the mean gain in the knowledge score of the control group.

The results are displayed in Table 9. They suggest a rejection of null hypothesis five. The results also show that the experimental group's mean gain score (31.46) is significantly greater than the control group's (11.86). Furthermore, it presents evidence that this difference is due to the new Worker I training program given the experimental group.

Table 9

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean Gain Scores</th>
<th>F-Value</th>
<th>Prob ＞ F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>31.46</td>
<td>19.19038</td>
<td>0.0001</td>
</tr>
<tr>
<td>(N=26)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>11.86</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(N=22)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Discussion

As discussed in earlier sections, the literature has revealed a lack of thrust in the development of new training programs for direct-care personnel (see Harmatz, 1973; Bensberg and Barnett, 1966 and Headrick, 1963). Moreover, Bensberg and Barnett, 1966 illustrate this point by stating:

"Attendant training programs have been in existence at least 100 years. In comparing the early programs with those in use today, a remarkable similarity can be found." (p. 24).

This contention is confirmed by Lash and Otness (1949); Oudenne (1963); and, again, Harmatz (1973).

The writer stated in earlier sections of his research that a study of the states revealed, for the first time, that a change in emphasis (and philosophy) in training programs was slowly taking place. These changes could be identified in Colorado (1974); Florida (1975); Georgia (1975); Louisiana (1975); and, Michigan (1975). More easily discernible was their change from a program involving the basic care and long-term commitment of the resident to an espoused philosophy of habilitation services and short-term care. Ohio's new Worker I curriculum also reflects this emphasis.

The assignment given to this writer was to test the viability of the curriculum, developed over the past eleven months, and then make recommendations regarding its use in Ohio's Institutions for the mentally retarded and developmentally disabled.

The primary concern of the writer was the increase in knowledge and performance among the experimental and control groups--over a short
time frame. Although the performance variable was not conclusive, it was the writer's opinion that even with the constraints of short-time span the number of participants in each group and the fact that the WWPI was the first of its kind developed that the increase of the experimental group's performance evaluations (compared to the decrease in performance evaluation in the control group) could be interpreted as being affected by the staff development program.

On the other hand, while the experimental and control groups failed a test of homogeneity with respect to performance, the same two groups were found similar in knowledge--and demographic characteristics. Both the experimental and control groups made statistically significant improvements in knowledge between pre and post tests (as measured by the OMRIS); and even more importantly, the experimental group's improvement was significantly greater than the control groups. This shows that the staff development curriculum had a significant impact upon the knowledge of the mental retardation worker who participated in both "on-ward" experiences and the staff development program.

Without including the performance variable (discussed previously) statistical analysis suggests that the experimental group (as shown in Figure 2) displayed significant increase in knowledge with on-ward experiences as compared to a lesser increase in knowledge due only to on-ward experiences (by the control group).

**Implications for Future Research**

Because the experimental group showed significant gains in their knowledge base (as measured by the OMRIS), over those gains achieved
Figure 2
On-Ward Experiences and Staff Development Program Versus On-Ward Experiences Only

Pre-test Period (May 7)  Time Interval (May 7-21)  Post-test Period (May 21-28)

Experimental Group (pre-test OMRIS)  Staff Development Exercises  Experimental Group (Post-test OMRIS)

(153.15)*

Control Group (Pre-test OMRIS)

(158.73)

On-Ward Experiences

No Staff Development Exercises

On-Ward Experiences

(184.61)

(170.59)

*Mean Test Scores Within Group
by the control group (who did not participate in the staff development program) it appears warranted to use the staff development program in future research. The writer would recommend a future study that placed its emphasis on measurement of the performance variable between and within groups.

Several factors would have to be taken into consideration in the development of the above-mentioned study. One, of course, is the size of the population to be tested. The writer believes a larger sample would be necessary to measure an increase in performance. Time span between the pre and post performance measures may play a part and might be lengthened in order to correctly reflect whether or not the staff development program actually increased performance. Additional measures should be added (e.g. an intelligence test; a test on reading ability) that may allow for the homogeneity of the two groups—with respect to performance. The investigation should be repeated in more than one environment in order to further isolate the performance variable.

Further research with respect to the change in attitudes of employee (because of added knowledge about mental retardation) is also recommended. Motivational aspects could also be measured. Additionally, the writer was unable to identify any research that measured the differences in a staff development project that allowed input from attendant personnel (input into the curriculum's content) versus one developed for attendants solely by professional staff. In other words, could it be expected that an attendant's knowledge, attitude, motivation, or
performance significantly increases because he or she had input into what he or she felt to be relevant subject matter? Or is the opposite true?

Finally, a review of the literature on direct-care personnel and their preparatory programs (see Butterfield, 1967 and Parnicky and Ziegler, 1964) shows that although many variables have been measured in the past (e.g. performance, attitudes, personality, etc.) that relatively few attempt to relate knowledge to other variables such as personality, attitudinal change, motivation, etc. The writer suggests research into each area mentioned with the final outcome being, hopefully, the transformation of the present direct-care worker.

These transformations could be reflected in many ways. One, the attitude of the attendant toward the mentally retarded resident would hopefully become more positive. Two, resident abuse would decrease. Three, a new emphasis on equal rights for the mentally retarded would hopefully occur. This emphasis (upon equal rights) started long ago for those residents not institutionalized; however, even with today's lawsuits (usually found in favor of the resident) equal rights for the institutionalized retarded have not become a reality.

Finally, further recommendations with respect to development of future training programs for direct-care personnel can be broken into two categories: (a) changes in the curriculum development and validation process; and, (b) recommendations to other states in development of their staff development programs.
Changes in the Curriculum Development and Validation Process

As indicated by the writer earlier, the development of the staff development curriculum for direct-care personnel was an extensive undertaking. While the writer personally felt the process was adequate, a few changes in process are indicated. These are:

(a) Development of a needs assessment instrument that is able to delineate the strengths and weaknesses of a training program.

(b) Direct involvement of the personnel to be served (in this case the direct-care worker) in the development of future training programs.

(c) Development of extensive tests of validity and reliability in order to better determine the content (or concepts) and the worth of a particular program and/or the measuring instruments.

(d) A multi-control group design could be chosen that would test not only whether a staff development training program produces results but what type of training (i.e. one group could be tested only on reading materials while another could be tested through a media format--while the third group remains as the control group) is best.

(e) A rather minor change on the surface, but one that took on more importance as time went on was release time for the Task Force. It was initially felt that one meeting a week would suffice, but this was not the case. Two or three day sessions are recommended to offset travel time, weather delay, etc.
(f) Train the trainers--more sufficient time to train the
trainers is needed so that they become familiar with the
format and content of a new staff development program and
teach it with understanding.

(g) Lines of communication between the committee developing the
staff development program and employee unions must remain
open. If this does not occur, a program may be developed
but never thoroughly tested.

Finally the curriculum development process does much to set the
tone for proper construction of a training program. These stages of
development represent a great deal of time and effort and should flow
as smoothly as possible. Professionals will want to concentrate on
the development of the training program and outside influences can
only be a detriment to this process.

Recommendations to Other States

It should be noted again, that many states are only now in the
planning stage for development of an effective staff development pro­
gram for direct-care personnel. It was noted by the author of this
investigation that many states exhibited deficiencies in their inservice
training materials because they did not have well defined sets of goals
and objectives outlining their particular staff development needs.
This resulted in ineffective inservice training materials. Recommen­
dations to other states follow:

(a) Every state must start with a process of defining which duties
they want to train an employee for--and then develop a staff
development program around those duties. For example, Ohio's Task Force developed a civil service classification to fit its Worker I program at the same time it was constructing its training module.

(b) Every state, if they have not done so already, should establish an Office of Staff Development, which will both disseminate and develop appropriate (and effective staff development programs).

(c) Every state should establish a state training newsletter and a staff development association both of which will keep staff development specialists up-to-date and assist them in learning new techniques from one another.

(d) All training sessions (utilizing new staff development programs) should approximate a valid experimental design that will then allow a state to measure the validity of a particular curriculum.

(e) Every state should conduct a nationwide survey of their own. This is important for at least one significant reason: each state's organizational structure is similar to some other state's system. If there are similar systems with staff development programs already developed it may save that state time and money.

(f) Every state should have an interstate curriculum committee whose membership is flexible enough to allow specialists in for development of a particular program. This would also
allow for a closer relationship with other states and their committees—which should promote exchange of ideas, etc. This committee would also be responsible for developing a state curriculum plan.

Finally, it is important to further emphasize that every state undoubtedly has the capacity to develop very fine training programs; however, if the professionals who are given the responsibility for implementing this program are not trained, all efforts will be to little avail. Proper training of the trainers is an important concept to keep in mind.

Summary

The results of the research showed that both groups made significant improvements in knowledge between pre and post tests; and, that most importantly, the experimental group's improvement was statistically significantly greater than the control groups. These results suggested that the staff development program (combined with on-ward experiences) had a significant impact on the mental retardation worker in the experimental group. The gains (31.46 for the experimental group as opposed to 11.86 for the control group) can be viewed as providing evidence that the Worker I training program will be successful in training direct-care personnel.

It will be this writer's recommendation to the Commissioner of the Division of Mental Retardation and Developmental Disabilities, Dr. Norman J. Niesen, that the new Worker I training program be implemented in each of Ohio's institutions for the mentally retarded. Moreover,
the writer has provided further recommendations discussed in the previous section regarding the testing of knowledge against other variables; i.e. attitudes, motivation, personality, performance, etc. However, immediate implementation of the new Worker I training program is recommended because of the new program's tested viability; and, because of Senate Bill 336, which requires that a new training program for direct-care personnel be implemented that will reflect short-term residency and habilitation services to each and every mentally retarded and developmentally disabled resident in Ohio's institutions.

Finally, the writer realizes that within the confines of this study there are two extremely important points to reiterate. One, of course, has been discussed in depth. That is the significant increase in the experimental group's knowledge scores over the three week staff development cycle. The fact that the experimental group displayed this increase at .01 level of significance suggests the viability of Ohio's new curriculum. Secondly, of course, is the process by which the mental retardation Worker I curriculum was written. In summary, these were:

(a) Selection of a statewide Task force by the Director of the Department of Mental Health and Mental Retardation which represented the wide variety of professionals and paraprofessionals serving either in Ohio's institutions or within the central office of the Division of Mental Retardation and Developmental Disabilities;

(b) Construction of training program content, based upon professional experiences and a survey of attendant training
programs nationwide;

(c) Selection of an Executive Committee to review the initial content of the training program;

(d) Selection of an Expert Panel to establish the final content validity of the training program; and,

(e) The final development of the six staff development modules based upon the Expert Panel and Executive Committee Evaluations.

This process was as much a part of establishing the efficacy of Ohio's Mental Retardation Worker I Curriculum as was the statistical treatment discussed earlier. These stages represent not only the length of time spent in developing and measuring an effective staff development program; but, more significantly, the level of importance placed upon finally achieving a direct-care worker training program that hopefully will result in improved services to Ohio's mentally retarded and developmentally disabled citizens. This, of course, was the eventual goal of both the author of this investigation and the Director's Statewide Task Force on Training.
APPENDIX A:
Department of Mental Health and Mental Retardation
Executive Orders on Training
OHIO DEPARTMENT OF MENTAL HYGIENE AND CORRECTION

EXECUTIVE ORDER NO. C-9

I. SUBJECT

Attendant and Psychiatric Aide Training

II. PURPOSE

To establish mandatory standards for in-service training of each ward-level employee in the Department's institutions.

To insure adequate basic training for each employee caring for patients.

To upgrade the quality of patient care by developing employee skills through continuing in-service educational programs.

III. APPLICATION

The provisions of this Order shall be applicable to all institutions under the managing responsibility of the Department, with the exception of the institutions under the Division of Correction.

IV. SUBJECT CONTENT

A. Each clinical employee functioning at the ward level and in contact with patients shall receive sufficient training to insure that he has the necessary skills to treat and care effectively for those patients in his charge. This training shall be:

1. Each new nursing staff employee shall receive eighty (80) hours of formal classroom instruction and eighty (80) hours of supervised ward experience. This training shall begin within twenty (20) days after his employment.

2. Each employee, upon completion of the above training, shall be eligible to enter into the Psychiatric Aide I training program which shall begin within twenty (20) days. After completion of this program, which shall consist of one hundred (100) hours of classroom training and one hundred (100) hours of supervised practice on a ward, the employee shall be promoted to the Psychiatric Aide I classification.

B. Guidelines for the implementation of this Order shall be:

1. During the implementation phase of these training programs, employees shall be selected for training according to seniority. Persons employed during this period shall be placed on a waiting list and shall receive training after the present employees have received official training.
EXECUTIVE ORDER NO. G-9

2. Standard manuals for the training described in this Order shall be prepared by the Division of Management Services and shall be used by institutional personnel to insure the inclusion of the proper subject matter in the courses.

3. The responsibility for the implementation of this Order shall be that of the institutional Managing Officer.

V. REFERENCES

A. Department Directives

Departmental Directive No. 66, Training Policy, May 23, 1960

VI. STATUTORY AUTHORITY: EFFECTIVE DATE

Adopted and Prescribed: April 10, 1972, pursuant to Ohio Revised Code Section 111.15.

Promulgated by Filing with Secretary of State on April 11, 1972.

Effective: April 21, 1972.
APPENDIX B:
Department of Mental Health and Mental Retardation
Executive Orders on Resident and Employee Transfer
EXECUTIVE ORDER NO. 0-11 (Revised October 1975)

I. SUBJECT
Cambridge Mental Health and Mental Retardation Center.

II. PURPOSE
To establish a separate developmental unit for the mentally retarded and developmentally disabled at Cambridge, Ohio, by changing the purpose, use, and name designation of the present Cambridge State Hospital; and to change the name of the institution to Cambridge Mental Health and Mental Retardation Center.

III. APPLICATION
The provisions of this Executive Order shall apply to all Divisions within this Department. All communications, records, and references to the institution shall reflect this designation.

IV. SUBJECT CONTENT
The institution presently designated as Cambridge State Hospital under the jurisdiction of the Division of Mental Health is hereby designated as Cambridge Mental Health and Mental Retardation Center. Those developmental units for mentally retarded residents will be under the jurisdiction of the Division of Mental Retardation and Developmental Disabilities. Said institution shall be known solely as Cambridge Mental Health and Mental Retardation Center, but the developmental units for the mentally retarded shall be considered by the Department as an extension of the Mount Vernon State Institute for all administrative, supervisory, programmatic, and personal matters until such time as this part of the facility is separated by the Department. The remaining Mental Health programs will continue to operate under the jurisdiction of the Division of Mental Health.

V. REFERENCES
Statutes
1. Ohio Revised Code Section 5119.01.
2. Ohio Revised Code Section 5119.03.
3. Ohio Revised Code Section 5119.05.
4. Ohio Revised Code Section 5119.46.
VI. STATUTORY AUTHORITY: EFFECTIVE DATE

Adopted and Prescribed: October 6, 1975 pursuant to Ohio Revised Code Section 111.15.

Promulgated by filing with the Secretary of State on October 6, 1975.

Pursuant to the specific power accorded me pursuant to Ohio Revised Code Section 111.15, I hereby declare that this Executive Order is a Rule and Regulation of an emergency nature necessary for the immediate preservation in the public peace, health, and safety. The reason for this necessity lies in the fact that services for the mentally retarded and developmentally disabled are needed and must commence immediately at this institution. Therefore, this Executive Order shall go into effect upon the day of its filing with the Secretary of State.

Effective: October 6, 1975.

Timothy B. Moritz, M.D.  
Director  

James A. Rhodes  
Governor
I. SUBJECT

Tiffin Mental Health and Mental Retardation Center

II. PURPOSE

To establish a program for the mentally retarded and developmentally disabled at Tiffin, Ohio, by changing the purpose, use, and name designation of the present Tiffin State Hospital; and to change the name of the institution to Tiffin Mental Health and Mental Retardation Center.

III. APPLICATION

The provisions of this Executive Order shall apply to all Divisions within this Department. All communications, records, and references to the institution shall reflect this designation.

IV. SUBJECT CONTENT

The institution presently designated as Tiffin State Hospital under the jurisdiction of the Division of Mental Health is hereby designated as Tiffin Mental Health and Mental Retardation Center. Those programs connected with Mental Retardation will be under the jurisdiction of the Division of Mental Retardation and Developmental Disabilities. The remaining programs will continue to operate under the jurisdiction of the Division of Mental Health.

V. REFERENCES

Statutes

1. Ohio Revised Code Section 5119.01.
2. Ohio Revised Code Section 5119.03.
3. Ohio Revised Code Section 5119.05.
4. Ohio Revised Code Section 5119.46.
VI. STATUTORY AUTHORITY: EFFECTIVE DATE

Adopted and Prescribed: September 19, 1975, pursuant to Ohio Revised Code Section 111.15.

Promulgated by filing with the Secretary of State on September 23, 1975.

Pursuant to the specific power accorded me pursuant to Ohio Revised Code Section 111.15, I hereby declare that this Executive Order is a Rule and Regulation of an emergency nature necessary for the immediate preservation in the public peace, health, and safety. The reason for this necessity lies in the fact that services for the mentally retarded and developmentally disabled are needed and must commence immediately at this institution. Therefore, this Executive Order shall go into effect upon the day of its filing with the Secretary of State.

Effective: September 23, 1975.

Timothy B. Moritz, M.D.  
Director  

James A. Rhodes  
Governor
EXECUTIVE ORDER NO. 0-13

I. SUBJECT
Athens Mental Health and Mental Retardation Center.

II. PURPOSE
To establish a program for the mentally retarded and developmentally disabled at Athens, Ohio, by changing the purpose, use, and name designation of the present Athens Mental Health Center; and to change the name of the institution to Athens Mental Health and Mental Retardation Center.

III. APPLICATION
The provisions of this Executive Order shall apply to all Divisions within this Department. All communications, records, and references to the institution shall reflect this designation.

IV. SUBJECT CONTENT
The institution presently designated as Athens Mental Health Center under the jurisdiction of the Division of Mental Health is hereby designated as Athens Mental Health and Mental Retardation Center. Those programs connected with Mental Retardation will be under the jurisdiction of the Division of Mental Retardation and Developmental Disabilities. The remaining programs will continue to operate under the jurisdiction of the Division of Mental Health.

V. REFERENCES
Statutes
1. Ohio Revised Code Section 5119.01.
2. Ohio Revised Code Section 5119.03.
3. Ohio Revised Code Section 5119.05.
4. Ohio Revised Code Section 5119.46.
VI. STATUTORY AUTHORITY: EFFECTIVE DATE

Adopted and Prescribed: September 19, 1975, pursuant to Ohio Revised Code Section 111.15.

Promulgated by filing with the Secretary of State on September 23, 1975.

Pursuant to the specific power accorded me pursuant to Ohio Revised Code Section 111.15, I hereby declare that this Executive Order is a Rule and Regulation of an emergency nature necessary for the immediate preservation in the public peace, health, and safety. The reason for this necessity lies in the fact that services for the mentally retarded and developmentally disabled are needed and must commence immediately at this institution. Therefore, this Executive Order shall go into effect upon the day of its filing with the Secretary of State.

Effective: September 23, 1975.

Timothy B. Moritz, M.D.
Director

James A. Rhodes
Governor
APPENDIX C

Worker I Classification Series

NATURE OF WORK IN THIS CLASS

This is introductory direct-care of mentally retarded persons in programs under the jurisdiction of the Division, including assignments in community agencies.

An employee in this classification is responsible for performing duties in accordance with established rules and procedures or on specific directions and/or orders from mental retardation workers of a higher grade, or other designated supervisory and/or professional staff members.

ILLUSTRATIVE EXAMPLES OF WORK

Shall provide direct service and/or care in accordance with the individual habilitation plan of the resident or client.

Shall provide physical care as appropriate to the resident or client, such as: bathing, feeding, mouth care, skin care, hair care, dressing, nail care, back care, positioning and foot care.

Shall provide immediate assistance, which includes bathing and reclothing, to the incontinent resident or client.

Shall provide continuous training opportunities for residents or clients in daily living activities and in the development of self help and social skills.

Shall observe, detect, and report overt signs of physical illness.

Shall take temperature, pulse, respiration and blood pressure.

Shall provide emergency first aide care, including seizure care.

Shall prepare basic reports as required by the program.

Shall participate in additional in-service training as required by institution and/or agency.

Shall provide for the safety, sanitation, and comfort of the resident or client.

May assist (as directed) professional staff members with various types of educational and training procedures within the individual habilitation plan.

May assist (as directed) the professional staff with the counseling and/or orientation of new residents being placed in the living unit.

May assist (as directed) the professional staff with counseling and orientation of new residents being re-integrated into the community.

May assist (as directed) in the in-service training of incoming M.R. Worker I's.
ESSENTIAL KNOWLEDGES, ABILITIES AND SKILLS

Basic knowledge of the principles of direct-care habilitation services, and programming for the mentally retarded individual.

Basic knowledge of the effects of medication.

Basic knowledge of the human body functions.

Ability to accurately report resident or client behavior and physical condition.

Knowledge of the institutional and departmental rules and regulations related to resident or client care.

Ability to follow detailed oral and written directions.

Ability to maintain attitudes which facilitate implementation of the residents or clients individual habilitation plan.

The necessary physical stamina to maintain efficient and effective direct-care to residents or clients.

The necessary emotional stability to maintain efficient and effective direct-care to residents or clients.

QUALIFICATIONS

For positions in the Department of Mental Health and Mental Retardation, this person must have successfully completed an approved departmental course and requirements of Mental Retardation Worker I in-service training.
APPENDIX D:

Director of the Department of Mental Health and Mental Retardation

Statewide Task Force on Training
SUBJECT: Committee Assignments for Development of Training Programs for Mental Retardation Aides I and II

I apologize for my delay in assembling names for the committee to develop a training and education program for the new classification of Mental Retardation Aide’s I and II. It is understood that the new classification will replace the Psychiatric Aide I and II classification for staff employed in Mental Retardation Facilities. Further, it is agreed that some of the content of the existing Psychiatric Aide Training Programs may be found appropriate for inclusion in the new training program.

May I suggest the following names for the Task Force Committee. All names preceded by an asterisk have been cleared with the appointing authority:

*Dr. Louis A. Mazzoli
*Mr. Michael J. Elshberry
Mr. George Khoury
Ms. Barbara Heretta
Mr. John Santose
Mrs. Laura Cornwell
Mrs. Louise Hustak
Mr. Robert Moorehead
Mr. Michael LaBuda

Central Office
Central Office
Orient State Institute
Columbus State Institute
Apple Creek St. Institute
Gallipolis State Institute
Broadview Center
Education and Training
Education and Training

On the Project’s Executive Committee may I suggest to you the following:

Dr. Milton McCullough
Dr. Norman Niesen
Dr. Bernard Nieman
Dr. Maxine Kays

Dr. Louis Mazzoli
Dr. Roger Gove
Mr. Robert Moorehead

Staff to the Executive Committee will be Michael Elshberry

TO: Milton W. McCullough, Assistant Commissioner
Office of Education and Training

FROM: Norman J. Niesen, Ed.D.
Commissioner

TO: Milton W. McCullough, Assistant Commissioner
Office of Education and Training

FROM: Norman J. Niesen, Ed.D.
Commissioner

SUBJECT: Committee Assignments for Development of Training Programs for Mental Retardation Aides I and II

I apologize for my delay in assembling names for the committee to develop a training and education program for the new classification of Mental Retardation Aide’s I and II. It is understood that the new classification will replace the Psychiatric Aide I and II classification for staff employed in Mental Retardation Facilities. Further, it is agreed that some of the content of the existing Psychiatric Aide Training Programs may be found appropriate for inclusion in the new training program.

May I suggest the following names for the Task Force Committee. All names preceded by an asterisk have been cleared with the appointing authority:

*Dr. Louis A. Mazzoli
*Mr. Michael J. Elshberry
Mr. George Khoury
Ms. Barbara Heretta
Mr. John Santose
Mrs. Laura Cornwell
Mrs. Louise Hustak
Mr. Robert Moorehead
Mr. Michael LaBuda

Central Office
Central Office
Orient State Institute
Columbus State Institute
Apple Creek St. Institute
Gallipolis State Institute
Broadview Center
Education and Training
Education and Training

On the Project’s Executive Committee may I suggest to you the following:

Dr. Milton McCullough
Dr. Norman Niesen
Dr. Bernard Nieman
Dr. Maxine Kays

Dr. Louis Mazzoli
Dr. Roger Gove
Mr. Robert Moorehead

Staff to the Executive Committee will be Michael Elshberry

cc: All the Above
November 21, 1975

Mr. Terry Hendrick
Program Director
Tiffin M.R. Unit
Tiffin, Ohio 44883

Dear Mr. Hendrick:

This letter is to officially appoint you to the Task Force on development of appropriate training programs for Mental Retardation Workers I and II, and Mental Retardation Supervisors. Welcome to Ohio, and I hope you enjoy your work at Tiffin, and on the Task Force.

Meetings of the Task Force, for the remainder of this year are as follows:

c. Thursday, December 18, 1975.
d. Tuesday, December 23, 1975.

Meetings commence at 10:00 a.m. and usually adjourn at approximately 2:00 p.m. They are held in room D202.

Sincerely yours,

Norman J. Niesen, Ed.D.
Commissioner

cc:
Michael J. Elsbury, Assistant to the Commissioner
Robert Moorehead, Office of Staff Development
Michael Labada, Office of Staff Development
Louis Mazzoli, Chief, Operations North
George Khoury, Orient State Institute
John Santoso, Apple Creek State Institute
Barbara Nicks, Columbus State Institute
Louis Bustak, Broadview Center
Laura Cornwell, Gallipolis State Institute
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John Santora, Apple Creek State Institute
Barbara Nitzsch, Columbus State Institute
Louise Mustak, Broadview Center
Laura Cornwell, Gallipolis State Institute
APPENDIX E:

Ohio's New Mental Retardation Worker I
Staff Development Program
APPENDIX E

FUNDAMENTALS OF MENTAL RETARDATION

MODULE I
I. **PRE-REQUISITES**

a) This is the beginning module of the M.R. Worker I training package. No prerequisites are necessary.

b) Comparable experience or knowledge.
II. DIRECTIONS FOR THE LEARNER

a) You will first be tested on your current knowledge of the fundamentals of Mental Retardation. Upon completion of this "Pre"-test, various learning experiences will be provided covering information concerning Fundamentals of Mental Retardation and Developmental Disabilities.

b) Upon completion of the learning experiences on Fundamentals of Mental Retardation. You will again be tested "Post"-test in order to determine your degree of comprehension.

c) Proceed at your own rate of speed. There are no time limits on this learning exercise. Notify your supervisor upon completion of this module. She/he will then coordinate your final examination on the information you learn in this learning experience. You will then be notified of your results. If you successfully pass the final examination you will then proceed to Module 2.

d) Good Luck -- enjoy your experience. Please proceed on to the "Pre"-test examination and begin answering each question to the best of your ability.
III. PRE-TEST

1. ________ refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period.

2. An individual with mental retardation must demonstrate deficits in both:
   1. __________ intelligence and appearance
   2. __________ attitude and adaptive behavior
   3. __________ adaptive behavior and measured intelligence
   4. __________ measured intelligence and attitude

3. The degree with which an individual meets the standards of personal independence and social responsibility expected of his/her age or cultural group is the definition of:
   1. __________ level of functioning
   2. __________ degree of severity
   3. __________ adjustment
   4. __________ adaptive behavior

4. ________ is defined as the effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected of his/her age or culture group.

5. There are four degrees of retardation recognized today. These are __________, __________, __________, __________.

6. __________ degree of retardation refers to individuals who are capable of social and vocational adequacy with proper individualized instruction.

7. __________ degree of retardation refers to those mentally retarded individuals who are capable, after appropriate training, of self-maintenance in unskilled or semi-skilled occupations.
8. _______ retarded individuals require continuing and close supervision but may perform self-help and simple work tasks under supervision.

9. _______ retarded individuals require continuing and close supervision but some persons may be able to perform simple tasks -- these individuals may times have other handicaps and require total life support systems for maintenance.

10. _______ and _______ are the two types of causes of mental retardation.

11. Which of the following terms best describes developmental difficulties during the months of pregnancy:

   1. _____ social deprivation
   2. _____ postnatal
   3. _____ prenatal
   4. _____ perinatal

12. The most common cause of M.R. during the prenatal period is:

   1. _____ accidents
   2. _____ infections, injuries, medication, poor nutrition
   3. _____ physical injuries to the head
   4. _____ lack of oxygen

13. Shortly after birth (postnatal) the most common causes of M.R. are:

   1. _____ accidents
   2. _____ lack of nutrition
   3. _____ improper controlled medication
   4. _____ infections; extremely high and uncontrolled fevers, physical injuries to the head.

14. The most common causes of M.R. during birth (perinatal) are:

   1. _____ difficult deliveries; prematurity and cord around the neck
   2. _____ accidents
   3. _____ lack of nutrition
   4. _____ infections
15. Matching (place the correct number by the appropriate definition)

a. Adaptive behavior
b. Attendant
c. Cerebral Palsey
d. Commitment (legal)
e. Day Care Program
f. Dependent M.R.
g. Developmental Disabilities
h. Evaluation
i. Habilitation Programs
j. Individual Functioning
k. Institution
l. Least Restricted Environment
m. Life Support Care
n. Normalization
o. Unitization
p. Right to Treatment

1. A concept emphasizing that the retarded person should have the same basic rights as other citizens.
2. The application of techniques for the systematic appraisal of the physical, mental, economic and intellectual resources of an individual.
3. A public or private facility that provides the care, treatment habilitations and rehabilitation of the resident.
4. The care necessary for some profoundly retarded individual with major medical problems.
5. The effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected of him/her.
6. A person employed to provide basic care and training services to the M.R.
7. A disability that is attributable to M.R. Cerebral Palsey, Epilepsy, etc...
8. A disorder dating from birth which is nonprogressive, characterized by paralyses, weakness and incoordination.
9. The ability of the resident to successfully accomplish the tasks or activities demanded of him by the institutions.
10. Assignment to custody, confinement or treatment by court order.
11. The process by which a staff of an institution assists the resident in acquiring and maintaining life skills which enables him to cope more effectively with the demands of his own person and the environment.
12. Providing optimal training of resident in an environment as free from constraints as possible.
13. The organization of an institution into units that will enhance training of the M.R.
14. The obligation of the State of Ohio to provide opportunities for its M.R.
15. An M.R. individual who requires continuing supervision or assistance in his/her social, academic functioning, and daily living.
16. Extended care services provided in the community.
16. There are approximately ____________ million M.R. in the U.S.

17. Only _________% of all retarded in the U.S. are located in institutions.

True/False
(Mark T for True and F for False)

18. ____All retarded persons look abnormal.

19. ____Mental retardation is a disease.

20. ____Mentally retarded individuals are criminals.

21. ____Mentally retarded individuals cannot be trained.

22. ____The Mentally retarded have special needs just like everyone else.

23. ____Most M.R. are retarded because of genetics.
IV. PURPOSE OF THIS MODULE

The purpose of this Module is to familiarize the Worker I trainee with the concepts of the Fundamentals of Mental Retardation.

V. ASSUMPTIONS

a) That the Worker I trainee will learn, through the various learning experience in this Module, the Fundamentals of Mental Retardation.

b) That the Worker I trainee has met the pre-requisites as outline on page 1.

c) That the Worker I trainee is self-motivated, and has a desire to successfully complete this training Module.

d) That any Worker I trainee who successfully passes the "Pre"-test will proceed immediately to Module 2.

VI. MOTIVATIONAL ASPECTS

a) It is necessary for the Mental Retardation Worker I trainee to gain a basic understanding of the Fundamental of Mental Retardation. This Module will provide for that understanding.
VII. TERMINAL OBJECTIVE

1.0 To understand the Fundamentals of Mental Retardation.

VIII. ENABLING OBJECTIVES

2.0 To understand the concept of mental retardation
2.1 To understand the four classes of mental retardation and each degree of retardation.
2.2 To understand the number of retarded in the U.S. and the prevalence within the four categories.
2.3 To understand the common fallacies within the field of mental retardation.
Go directly to your readings attached to the back of your Module.
Read all material. Review your "pre-test". Can you now answer all
the questions? If so, notify your supervisor and request a final exam
on Module I.
IX. ATTACHMENT TO MODULE I
A. WHAT IS MENTAL RETARDATION?

a. Definition of Mental Retardation.

Mental Retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period.

Only those individuals who demonstrate deficits in both measured intelligence and adaptive behavior are classified as being mentally retarded.

<table>
<thead>
<tr>
<th>INTELLECTUAL FUNCTIONING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retarded</td>
</tr>
<tr>
<td>Mentally Retarded</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(ADAPTIVE BEHAVIOR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retarded</td>
</tr>
<tr>
<td>Not Mentally Retarded</td>
</tr>
</tbody>
</table>

b. Definition of Adaptive Behavior.

Adaptive behavior is defined as the effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected of his or her cultural group.

c. Definition of Intellectual Functioning.

Intellectual Functioning refers to significantly subaverage I.Q. scores as measured by one or more of the standardized tests (i.e. Stanford-Binet/Wechsler).
B. CLASSIFICATIONS AND DEGREES OF MENTAL RETARDATION

As attendants (M.R. Workers) you will be providing your services to four categories of Mentally Retarded individuals. According to the American Association of Mental Deficiency the mentally retarded show the following degrees of retardation:

I. **Level I** (Mild - I.Q. range: 55-69)
   - Can develop social and communication skills; minimal retardation in sensori-motor areas; rarely distinguished from normal until later age.

II. **Level II** (Moderate - I.Q. range: 40-54)
   - Can talk or learn to communicate; poor social awareness; fair motor development; may profit from self-help; can manage with close supervision.

III. **Level III** (Severe - I.Q. range: 25-39)
   - Some can learn functional academic skills to approx. 2nd grade level by late teens if given special education ("Trainable")

IV. **Level IV** (Profound - I.Q. range: 0-24)
   - Incapable of self-maintenance in unskilled or semi-skilled occupations; needs close supervision & help when under mild social or economic stress.

It is important for you, as the person who is/will be associated with them the most to know their levels of adaptive behavior. Remember, adaptive behavior is defined as the effectiveness or degree with which the mentally retarded individual meets the standards of personal independence and social responsibility expected of his/her age of cultural group.

The table exhibited below breaks down the degree of classifications into 3 age groups of Pre-school; School-age; and Social and Vocational adequacy.

<table>
<thead>
<tr>
<th>LEVELS OF ADAPTIVE BEHAVIOR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-School Age</strong></td>
</tr>
<tr>
<td>0-5 Maturation &amp; Development</td>
</tr>
<tr>
<td>Level - I (Mild)</td>
</tr>
<tr>
<td>55-69 I.Q.</td>
</tr>
<tr>
<td>Level - II (Moderate)</td>
</tr>
<tr>
<td>60-54 I.Q.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Level-III</th>
<th>Pre-School Age 0-5 Maturation &amp; Development</th>
<th>School-Age 6-21 Training &amp; Education</th>
<th>Adult 21 Social &amp; Voc. Adequacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Severe)</td>
<td>Poor motor development speech is minimal; generally unable to profit from training in self-help; little or no communication skills.</td>
<td>Can talk or learn to communicate; can be trained in elementary health habits; cannot learn functional academic skills; profits from systematic habit training. (&quot;Trainable&quot;)</td>
<td>Can contribute partially to self-support under complete supervision; can develop self-protection skills to a minimal useful level in controlled environment.</td>
</tr>
<tr>
<td>25-39 I.Q.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level - IV</td>
<td>Gross retardation; minimal capacity of functioning in sensori-motor areas, needs nursing care.</td>
<td>Some motor development present; cannot profit from training in self-help; needs total care.</td>
<td>Some motor speech development; totally incapable of self-maintenance; needs complete care and supervision.</td>
</tr>
<tr>
<td>(Profound)</td>
<td>0-24 I.Q.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
C. CAUSES OF MENTAL RETARDATION

Introduction

I. Acquired Causes
   A. Prenatal
   B. Perinatal
   C. Postnatal
   D. Social Deprivation

II. Inherited Causes
   A. Parents of Low Intelligence
   B. Metabolic Errors
      1. Phenylketonuria
   C. Chromosome Aberrations
      1. Mongolism
C. CAUSES OF MENTAL RETARDATION

Mental retardation refers to significantly subaverage, general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period.

Causes are basically disease, accident, defective body function, inheritance and social deprivation. There are still many unknown factors.

Causes are generally classified under two terms - acquired and inherited.

I. Acquired - disease and injury are common causes of mental retardation. Tissue damage of the brain cells may occur during disease or injury causing a loss of total function of the brain. There are several stages in an infant development when injury or disease can effect their development.

A. Prenatal (before birth) - causes of developmental difficulties which occur during the months of pregnancy.

1. Infections - infections during pregnancy can be disasterous. Especially during the first 3 months.
   a. viral infections of the mother are common causes of birth defects. Cause destruction of brain and body tissue. Prohibit proper development.
   b. prevalent offenders - measles, German measles, influenza, syphilis

2. Injuries - can be caused by other means
   a. Rh factor - blood of the mother's body may build up antibodies against the Rh+ blood of the fetus, (unborn child), causing destruction of brain and body tissue and retarding their development. Death may occur if the condition remains untreated.
   b. toxemia - metabolic disturbances may occur during pregnancy causing a build-up of toxic substances which can severely endanger the fetus and mother.
   c. medications - many types of medication if taken during pregnancy can cause serious effects on the fetus. Interference with normal development may occur or actually destroy brain or body tissue.
   d. Poor nutrition - interference with the blood supply from the mother to the child, may cause a decrease in nutrition, and oxygen supply to the fetus.
   e. X-rays (radiation)
B. Perinatal (during birth)

1. Difficult deliveries - may result in head injuries or impairment of the oxygen supply to the brain

2. Prematurity - the infant may not be sufficiently developed to function outside the womb.
   a. insufficient ability to breath and to utilize oxygen will cause irreversible brain damage
   b. inability to swallow or utilize nutrition

3. Postnatal (shortly after birth)

1. Infections - newborns are more susceptible to a number of infections. If resulting in meningitis or encephalitis can cause brain damage.

2. Extremely high and uncontrolled fevers will contribute to brain damage.

3. Physical injury to the head - (skull fracture and cerebral hemorrhage)

4. Lead-free paints (lead poisoning).

D. Social Deprivation - This term refers to children who are deprived of a normal environment which would provide sufficient experience to advance to normal intelligence. There are not enough stimulating factors to allow the child to learn. There usually is no significant organic disease in this category. Other contributing factors would be a typical parent-child relationship such as prolonged isolation during the developmental years.

II. An individual's degree of intelligence can be an inherited factor the same as any other characteristic. The color of hair, shape of nose, etc. are all destined by genetic make-up of a child's parents. The same can be applied to intelligence.

A. Parents of low intelligence
B. Metabolic errors – when certain necessary chemicals or enzymes are missing in the body, proper body metabolism cannot take place, mental retardation is many times the result.

Phenylketonuria (commonly called PKU) – is the outstanding example of this type of disorder.

1. It is a genetically determined disorder by a recessive fashion with both parents being carriers.
2. Occurs approximately 1 in every 25,000 births.
3. The body can not convert certain foods into proper chemicals which needs to be put to use for the body.
4. Results in physical and mental retardation.
5. Testing – a simple test can be performed shortly after birth to detect the presents of this condition.
   - Blood analysis
   - Diaper test
6. Prevention – retardation can usually be prevented by following a low protein diet.
C. Chromosome Aberrations - it has been found that with certain types of mental retardation, there is an alteration in the number of chromosomes in the individual's cells. Normally there are 46.

Mongolism is a common example. These individuals have 47 chromosomes. The condition is referred to as Mongolism because of the characteristic facial features. Narrow eyes and a broad flat face. It is considered an accident of life. The incidents of Mongolism rises with the age of the mother. Mothers over 40 are more apt to deliver mongoloid children than younger women.
D. TERMINOLOGY IN MENTAL RETARDATION

1. Adaptive Behavior: Is defined as the effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected of his or her cultural group.

2. Attendant: A person who is employed to provide supervision and guidance as well as basic care and training services to the individual living within a residential facility (institution). May also be referred to as a worker, and/or direct-care worker.

3. Cerebral Palsey: A disorder dating from birth or early infancy, which is non-progressive, characterized by examples of poor motor functioning (paralysis, incoordination, etc.) and often other problems such as brain damage, seizures, mental retardation, and learning and behavioral disorders.

4. Commitment (Legal): Assignment to custody, confinement or treatment by Court Order.

5. Day Care Program: Extended care services provided on an ongoing basis for individuals residing in the community. Day care programs involve social, physical, recreational and personal care training and activity.

6. Dependent Mental Retardation: A Mentally Retarded Individual who requires continued supervision or assistance in his/her social, academic, and daily living skills.

7. Developmental Disability: A disability that can be attributed to mental retardation, cerebral palsey, epilepsy, etc. It is closely related to mental retardation and originates in childhood. It is likely to continue throughout life.

8. Evaluation: The appraisal of an individual, by the application of techniques that show the physical, mental, social, economic, and intellectual resources of an individual and his/her family.

9. Habilitation Program: The process by which the staff of an institution, assists the resident in acquiring and maintaining those life skills which enables him/her to cope more effectively with the demands of his/her own person and of his/her environment. Hopefully, it also raises the physical, mental, social and vocational efficiency of the individual resident.
| 10. Independent Functioning: | The ability of the individual to accomplish successfully those tasks or activities demanding of him/her by the general community, both in terms of critical survival demands within the community and in terms of typical expectations of specific age groups. |
| 11. Institution: | Also called a residential facility. A public or private facility or building(s) providing professional services (24 hour basis) for the mentally retarded. Those services include the care, treatment, habilitation and rehabilitation of the mentally retarded. |
| 12. Least Restrictive Environment: | Providing for optimal training of residents in an environment as free of constraint as possible, within the institutional setting. |
| 13. Life Support Care: | The care necessary for some profoundly retarded individuals with major biochemical problems. For example, they may require oxygen, special feeding, etc. |
| 14. Normalization: | A term meaning that the mentally retarded person has the same basic rights as any other human being. For example, they have the same right to legal representation as anyone else. |
| 15. Right to Treatment: | The obligation of the State of Ohio, to provide its mentally retarded residents with opportunities to develop physically, mentally, socially and vocationally. |
| 16. Unitization: | The organization of an institution into effective units, to better enhance both the education and training of the mentally retarded. |
E. INCIDENCE AND PREVALENCE OF MENTAL RETARDATION

At present, there is an estimated 5.6 million mentally retarded individuals in the United States. The prevalence of this condition is exceeded by only four other health problems: mental illness; heart disease; arthritis and cancer.

Of the 5.6 million, 285,000 are severely or profoundly retarded and will need lifetime care and supervision; 350,000 are moderately retarded, capable of self-maintenance in unskilled or semi-skilled occupations; and 5 million are mildly retarded, capable of social and vocational adequacy with proper education and training.

More than 200,000 mentally retarded individuals reside in 150 public institutions around the country. Another 20,000 mentally retarded live in approximately 500,000 known private institutions. These figures represent fewer than 5% of all the retarded in the United States.
F. COMMON FALLACIES ABOUT THE MENTALLY RETARDED

The common fallacies (statements that are NOT true) about mental retardation are listed below. Many people in society believe them to be true. YOU, as an attendant should NOT believe them. Again, the following are NOT true:

1. All mentally retarded persons look abnormal.
2. Nothing can be done for the mentally retarded.
3. All mental retardation is inherited at birth.
4. All mentally retarded should be institutionalized.
5. All mentally retarded children are born to older parents.
6. All mentally retarded children are left-handed.
7. Only children with an I.Q. over 50 can be trained.
8. All mongoloid children have an I.Q. below 30 and most die as babies.
9. Mentally retarded children will never be useful in society.
11. Mentally retarded children are never emotionally disturbed.
12. Speech defects in a mentally retarded child cannot be corrected.
13. The mentally retarded are possessed by demons.
15. Retarded children are not gratifying to work with.
16. Mentally retarded children bring shame upon their family.
17. Mental retardation is a disease.
18. Mental retardation is based on I.Q.
19. Special training for personnel working with the retarded is not needed.
20. Mentally retarded children are over-sexed.
21. Mentally retarded children have criminal tendencies.
22. Research into mental retardation is not necessary.
SENATE BILL 336, AS AMENDED, OR: (UNDERSTANDING THE
CIVIL AND HUMAN RIGHTS OF RESIDENTS AS REFLECTED IN THE
OHIO LAW)

MODULE II
I. **Prerequisites**

a. This learning experience assumes that you have successfully completed Module I of the Worker I Training Package.

b. Comparable experience or knowledge.
II. Directions for the Learner

a. You will first be tested on your current knowledge of Senate Bill 336, as amended. Upon completion of the "pre"-test, various learning experiences will be provided covering information concerning Senate Bill 336.

b. Upon completion of the learning experiences on Senate Bill 336, you will again be tested, post-test, in order to determine your degree of comprehension.

c. Proceed at your own rate of speed. There are no time limits on this learning module. Notify your supervisor upon completion of the module, and he/she will then coordinate your final examination. You will then, upon completion of the final examination, be notified as to the results.

d. Good luck - enjoy your experience. Please proceed on to the "pre"-test examination and begin answering each question to the best of your ability.
III. Pre-Test

1. Senate Bill 336, as amended, is designed to:

   ___a. insure that the mentally retarded people in the State of Ohio retain all the rights that are afforded other citizens.

   ___b. prevent inappropriate institutionalization.

   ___c. assure appropriate treatment and humanized environments within the institutional setting.

   ___d. address the ways in which a citizen may be admitted to or discharged from, an institution.

   ___e. all of the above

   ___f. none of the above

   ___g. a and b above

2. As a mental retardation worker, which one of the following expressed purposes of Senate Bill 336 will you most be directly involved with:

   ___a. to promote the human dignity and to protect the constitutional rights of the mentally retarded in the State of Ohio.

   ___b. to encourage the development of the ability and potential of each mentally retarded person in the State to the fullest possible extent, no matter how severe his disability.

   ___c. to promote the economic security, standard of living, and meaningful employment of the mentally retarded.

   ___d. to recognize the need of mentally retarded persons, to live in surroundings and circumstances as close to normal as possible.

   ___e. all of the above

   ___f. none of the above

   ___g. a and b above
3. Persons hired to work with residents within institutions for the retarded, must be in agreement with the principals set forth in Senate Bill 336, and will conscientiously protect the rights of the clients.
   ___a. true
   ___b. false

4. An employee of the Division of Mental Retardation, who deliberately denies a client's civil rights will be subject to disciplinary action and may be:
   ___a. libel to civil action
   ___b. libel for slander
   ___c. subject to contract disobedience
   ___d. committing a crime against the State

5. An employee of an institution may be named guardian of a client who resides in the institution.
   ___a. true
   ___b. false

6. All residents are allowed to:
   ___a. receive visitors
   ___b. have reasonable access to telephones
   ___c. have reasonable access to writing materials and postage
   ___d. a and b above
   ___e. all of the above
   ___f. none of the above
7. Under Senate Bill 336, there are two types of admissions. They are called:
   ___a. client and entrance admissions.
   ___b. community and resident admissions.
   ___c. voluntary and involuntary admissions.
   ___d. parent and court admissions.

8. Any non institutionalized person, who may be mentally retarded, may apply for:
   ___a. trial visit status
   ___b. voluntary admission
   ___c. involuntary admission
   ___d. discharge

9. The above-mentioned type of admission (in question 8) is only approved by the Division of Mental Retardation if:
   ___a. the client under consideration truly desires to become a resident.
   ___b. it is in the best interest of the individual who is applying
   ___c. all tests and evaluations indicate some degree of mental retardation
   ___d. the parent or guardian approves the admission

10. Under Senate Bill 336, what admission must be made through the Courts?
    ___a. voluntary admissions
    ___b. trial admissions
    ___c. involuntary admissions
    ___d. right to treatment admission
There are two classes of clients who may be admitted involuntarily, to our State's Institutions. They are:

a. those who represent a substantial danger to themselves and those who represent a substantial danger to the general public.

b. those who represent a substantial danger to themselves and those who are unable to provide for their most basic physical needs.

c. those who represent a problem to the courts and those who represent a problem to the community.

d. those who are without a guardian and those who desire to be admitted.

Potential clients are eligible for court commitment (involuntary commitment) even when provisions for meeting their needs are available in the community.

a. true

b. false

Those persons who are moderately, severely, or profoundly retarded may be court committed (involuntarily) only when two other conditions (in addition to their degree of retardation) are present. These other two conditions are: Please check two:

a. when a person represents a substantial danger to himself/herself and is unable to provide for his/her basic needs

b. adequate community resources are not available

c. the parent and/or guardian and client agree to be involuntarily committed.

d. a and b above
14. Senate Bill 336 protects the individual client against abuse. Any worker who suspects that a client has been abused or neglected must immediately report this abuse or neglect to the Superintendent. A written report must be filed which describes:
   a. ____________________________________________.
   b. ____________________________________________.
   c. ____________________________________________.

15. The law provides that any person who reports or testifies in an abuse case will have ___________________________ from civil or criminal prosecution on matters surrounding the alleged incident.
   ___a. amnesty
   ___b. immunity
   ___c. no immunity
   ___d. all of the above

16. A client may not perform labor for the support and maintenance of the facility without receiving ____________________________ in accordance with the Fair Labor Standard Act.
    ___a. wages
    ___b. free time
    ___c. free lunches
    ___d. overtime

17. The clients Individual Habilitation Plan (IHP) is a plan which will assist the resident in their:
    ___a. maximum adjustment to the community
    ___b. maximum adjustment to the institutional environment
    ___c. maximum social, emotional and/or physical development
    ___d. daily activities
18. The correct definition of an individual habilitation plan is:
   ___a. a plan for the daily work activities of the resident
   ___b. a plan for administering medication to the resident
   ___c. a plan that will help the resident receive maximum
       social, emotional and physical development
   ___d. a "last resort" plan for the resident before he becomes
       confined to the institution for life
IV. Purpose of this Module
   a. The purpose of this module is to familiarize the Worker I aspirant, with the concepts of Senate Bill 336.

V. Assumptions
   a. That the Worker I aspirant will learn, through the various experiences outlined in this module, the basic construct of Senate Bill 336.
   b. That the Worker I aspirant has met the prerequisites as outlined on page 1.
   c. That the Worker I aspirant is self-motivated, and has a desire to successfully complete the training module.
   d. That any Worker I aspirant who may pass the "pre"-test will proceed immediately to Module 6.

VI. Motivational Aspects
   a. It is important for the Worker I aspirant to gain a basic understanding of Senate Bill 336, the basic right to treatment law for Ohio's mentally retarded. This module will provide for that basic understanding.
VII. Terminal Objective

1.0 - To understand the constructs of Senate Bill 336, as they apply to the individual resident and how Senate Bill 336 affects the Worker.

VIII. Enabling Objectives

2.0 - To identify the key elements of the civil rights section of Senate Bill 336.

2.1 - To understand the two concepts of voluntary and involuntary admissions under Senate Bill 336.

2.2 - To identify the two classes of clients that can legally be involuntarily committed under Senate Bill 336.

2.3 - To identify the three conditions necessary for involuntary commitment under Senate Bill 336.

2.4 - To identify a worker's responsibility in reporting and testifying on resident abuse, under Senate Bill 336.

2.5 - To understand the definition of resident labor under Senate Bill 336.

2.6 - To understand, and define, habilitation under Senate Bill 336.
**Problem:**

This is essentially a reading module. The readings, listed below, are provided for your information. Read each carefully, since you will then be tested on the contents of the readings. They are:

a. Introduction to Senate Bill 336, As Amended.
b. The Civil Rights of Residents under Senate Bill 336
c. Voluntary and Involuntary Admissions under Senate Bill 336
d. Resident Abuse
e. Resident Labor
f. The Individual Habilitation Plan (IHP)
IX. ATTACHMENTS TO MODULE 2
Attachment 1

INTRODUCTION TO SENATE BILL 336, AS AMENDED

Senate Bill 336, enacted by the 110th General Assembly of the State of Ohio, and involving changes in Chapter 5123 of the Ohio Revised Code, became effective on July 1, 1975. As such, it mandates certain provisions related to several aspects of the care of the mentally retarded.

Although the text of Senate Bill 336 is extensive and often difficult to understand, the purpose of the law is clear. Basically 336 is designed to insure that mentally retarded persons in the State of Ohio retain all the rights that are afforded to other citizens. Further, the law sets forth strong provisions which prevent and remediate inappropriate institutionalization. It assures appropriate treatment and a humanized environment for those that are institutionalized. Last, the law particularly addresses the ways in which a citizen may be admitted to an institution, and ways in which he or she may be discharged, and the responsibilities of the Division during the time that the person is under its care.

Specifically, the expressed purposes of the enactments relating to Chapter 5123 are as follows (Section 5123.67):

A. To promote the human dignity and to protect the constitutional rights of mentally retarded persons in the State of Ohio;

B. To encourage the development of the ability and potential of each mentally retarded person in the State to the fullest possible extent, no matter how severe his degree of disability;

C. To promote the economic security, standard of living, and meaningful employment of the mentally retarded;
D. To maximize the assimilation of the mentally retarded persons into the ordinary life of the communities in which they live; and,

E. To recognize the need of mentally retarded persons, whenever care in a residential facility is absolutely necessary, to live in surroundings and circumstances as close to normal as possible.
THE CIVIL RIGHTS OF RESIDENTS IN INSTITUTIONS

Senate Bill 336 is specific in setting forth the civil rights of persons under the care of the Division of Mental Retardation's Institutions. It is the policy of the Division to recognize these rights, and to comply with the spirit as well as the letter of the law.

The key to protecting these rights is staff attitudes. All facilities will IMMEDIATELY initiate a program of inservice training designed to inform staff members of the provisions of the law, and to encourage staff attitudes consistent with the law. All facilities must review their hiring procedures, and modify them where necessary to ensure that persons hired are in philosophical agreement with the principles set forth, and will conscientiously protect the rights of the clients.

Any employee of the Division of Mental Retardation who deliberately denies a client's civil rights will be subject to disciplinary action, and may be liable to civil action. Persons entering the institution, on both voluntary and involuntary status under court order retain the same rights and will be subject to the same habilitation procedures not specifically denied persons in institutions by law.

All clients in institutions retain legal competency unless a specific finding to the contrary has been made. Under no condition is the superintendent or any other employee of an institution to be named guardian or a client who resides in the institution.

All clients will be allowed to receive visitors, including a personal attorney or physician, at reasonable times. Each managing officer shall establish and publish the visitation schedule for his or her institution. Exceptions must be handled by the managing officer.
All clients shall have reasonable access to telephones, in order to make and receive confidential calls. At least one pay phone must be installed at each facility for client use.

The Superintendent will establish guidelines to insure each client a reasonable number of calls. This includes money for calls, if the client has no financial resources, and provisions for assistant in calling if required.

All clients shall have reasonable access to writing materials and postage. Client's mail is not to be opened by institute staff. At least one mailbox must be provided for outgoing mail. The Superintendent will establish guidelines to provide reasonable postage for clients who have no financial resources, and to provide assistance in writing if required.
Attachment 3

**VOLUNTARY & IN VOLUNTARY ADMISSIONS**

The worker should be aware that there are two types of admissions, under Senate Bill 336, to Ohio’s institutions for the mentally retarded. These are called voluntary and involuntary admissions.

**Voluntary Admissions**

Senate Bill 336 states that any person 18 years of age or older, who may be mentally retarded, or the guardian if the client is adjudicated incompetent, may APPLY for voluntary admission to an institution. The parents or guardian may apply for the admission of a minor.

At the conclusion of an evaluation and joint staff meeting, if institutionalization is indicated a contract for services for the voluntarily committed resident will be developed. This contract will outline the rights and responsibilities of the Division of Mental Retardation, the institute staff, the family or guardian—and, most importantly, the client. The contract will bind the institution to carry out certain training and habilitation procedures, and makes the Division of Mental Retardation responsible for the placement and followup of the client once his/her habilitation plan is carried out.

Finally, voluntary admissions are only approved by the Division of Mental Retardation IF IT IS IN THE BEST INTERESTS OF THE INDIVIDUAL WHO IS APPLYING. Certain legal constraints may be invoked by the Ohio Legal Rights Service to determine whether or not institutionalization is in the best interest of the individual client.
Involuntary Admissions

Under law, all involuntary commitments must be made through the Courts. All involuntary commitments are made for a specific time limit. Senate Bill 336 makes the involuntary commitment process complex, time consuming, and restrictive.

There are TWO CLASSES of clients who may be involuntarily committed. The first class consists of persons who, because of their degree of mental retardation represent a substantial danger to themselves, because they are unable to provide for their most basic physical needs. Moreover, there is the stipulation that even these individuals are eligible for court commitment ONLY if provisions for meeting these needs are not available in the community.

There are then, three conditions which must be present before one individual is eligible for involuntary commitment under Senate Bill 336. These conditions are:

a. Moderate, severe, or profound mental retardation.

b. Substantial danger to self because of inability to meet basic physical needs; and,

c. Lack of appropriate community resources to help the individual.

The second class of clients who MAY be involuntarily committed to an institution are those moderately, severely, or profoundly retarded who are, "susceptible to significant habilitation in an institution." (5123.68 K2). The important considerations here are:
a. Whether or not there are appropriate programs available in the institution.

b. Resources in the community.

c. The potential of the client in question.
knowledge or upon knowledge thought to be reliable, " are free from financial liability from clients or others bringing suit for alleged mistreatment of clients of the Division of Mental Retardation. However, this provision (5123.91) DOES NOT protect employees whose actions make them SUSCEPTIBLE TO CRIMINAL PROSECUTION.
RESIDENT ABUSE

Senate Bill 336 protects the individual client against abuse. Any worker who suspects that a client has been abused or neglected must immediately report this abuse or neglect to the Superintendent. A written report must be filed which describes the client's condition; the nature of the injuries; and the possible cause of the injuries.

Once the Superintendent has been informed of abuse charges, of a serious nature (death or serious injury) he may:

1. Request that the Ohio State Patrol (or local police officials) investigate the incident.

2. Report to the Division of Mental Retardation the abuse incident.

3. Report to the Division of Mental Retardation the abuse incident.

4. Provide assistance to the investigating agency.

5. Remove the resident in question from the facility if it is judged essential to preventing further injury to the resident.

Further, the law provides that any person who reports or testifies in an abuse case will have immunity from civil or criminal prosecution on any matters surrounding the alleged incident and relating to their testimony about said incident.

Employees who act, "reasonably and in good faith, upon actual
Attachment 5

RESIDENT LABOR/HABILITATION PLANNING

Senate Bill 336 states that clients may not perform labor for the support and maintenance of the facility without receiving pay in accordance with the FAIR LABOR STANDARDS ACT. (5123.87).

The Individual Habilitation Plan (IHP)

Senate Bill 336 requires that residents in state institutions receive habilitative services based on their comprehensive evaluations. Further, Senate Bill 336 mandates that each resident will have an IHP based on his or her evaluated needs. Also, each IHP will be evaluated every 90 days.

Procedures for developing IHPs will be discussed in Module 3. Presently, it is only necessary for the Worker I aspirant to understand that each resident is being trained under a specific IHP—and that he or she should have a knowledge of what is included within the IHP.

Defined, Habilitation means constructing a program that will assist the resident in his or her maximum social; emotional; and/ or physical development.
HABILITATION PROGRAMMING FOR THE RETARDED - ITS IMPORTANCE AND PURPOSE

MODULE III
I. PRE-REQUISITES

a) This learning experience assumes that you have completed Modules 1 and 2 of the M.R. Worker I Training Package.

b) Comparable experience or knowledge.
II DIRECTIONS FOR THE LEARNER

a) You will first be tested on your current knowledge of Habilitation Programming. Upon completion of this "Pre-test", various learning experiences will be provided covering information concerning Habilitation Programming.

b) Upon completion of the learning experiences on Habilitation Programming, you will again be tested, "Post-test", in order to determine your degree of comprehension.

c) Proceed at your own rate of speed. There are no time limits on this learning exercise. Notify your supervisor upon completion of this Module. She/he will then coordinate your final examination on the information you learn in this learning experience. You will then be notified of your results. If you successfully pass the final examination you will then proceed to Module 4. If you do not successfully pass the final examination, you will have to study this Module until you do.

d) Good Luck -- enjoy your experience. Please proceed on to the "Pre-test" examination and begin answering each question to the best of your ability.
III. Pre-Test

Each learner is asked to answer all of the questions indicated below. There are twenty such questions. Some are of the true or false variety. Others are of a multiple choice nature. Still other questions require that the best answer be placed in the blank provided. Work as fast and as carefully as possible. If you do not know the correct answer or are uncertain, do not hesitate to guess. Answer these questions honestly without recourse to reference material such as is provided in the text of the module itself. This examination is for self-instruction and is provided for the student's diagnosis of his own knowledge deficiencies. There are twenty questions.

1. Habilitation refers to ________________________________

2. Programming refers to ________________________________

3. Increase in the frequency of a behavior can be accomplished through ________________________________

4. Systematic checking and observation of behavior following prescribed time periods is known as a ________________________________ procedure.

5. Using small steps to reach a certain kind of behavior is known as ________________________________

6. Abilities to toilet, eat, dress and groom are known as basic ________________________________ skills.
7. Habilitation programming is only for retarded persons and would not be helpful for persons of normal intelligence.
   ___a. true
   ___b. false

8. Habilitation does not refer to skills necessary for living.
   ___a. true
   ___b. false

9. A well-designed plan is necessary in order that proper habilitation occur.
   ___a. true
   ___b. false

10. Teaching from an habilitation plan should be measured in small steps.
    ___a. true
    ___b. false

11. It is unimportant for results of a positive nature to follow a particular behavior.
    ___a. true
    ___b. false

12. Habilitation planning only includes those behaviors associated with personal needs and does not deal with social or vocational behaviors.
    ___a. true
    ___b. false
13. A proper Habilitation plan specifies behavioral objectives and means for attaining them.

   ___a. true  
   ___b. false

14. Habilitation programming:

   ___a. is unnecessary with retarded residents  
   ___b. is necessary with retarded residents  
   ___c. is not at all helpful  
   ___d. is useful in all cases without exception  
   ___e. all of the above  
   ___f. none of the above

15. Reinforcement:

   ___a. refers to increases in frequency of behavior  
   ___b. refers to decreases in frequency of behavior  
   ___c. has no specific reference to behavior  
   ___d. is always necessary following the emission of the specified response  
   ___e. all of the above  
   ___f. none of the above

16. Shaping:

   ___a. is an unscientific tool  
   ___b. is unnecessary in most instances  
   ___c. is lacking in precision  
   ___d. is a useful tool in teaching complex series of behaviors  
   ___e. all of the above  
   ___f. none of the above
17. Basic self-help skills:
   ___a. include toileting, dressing, eating, and grooming
   ___b. refer to skills necessary for happiness in life
   ___c. frequently require teaching to retarded residents
   ___d. are basic to performance of other activities in life
   ___e. all of the above
   ___f. none of the above

18. With retarded residents:
   ___a. it is unnecessary to teach community living skills
   ___b. it is unnecessary to teach job-related skills since most
       retarded persons are lazy and do not work anyway
   ___c. it is unnecessary to carefully observe behavior since
       retarded persons do not do very much
   ___d. it is unnecessary to provide consistent reinforcement
   ___e. all of the above
   ___f. none of the above

19. Intermittent reinforcement:
   ___a. provides reinforcement on a specified schedule
   ___b. is good for maintaining a behavior once established
   ___c. promotes great resistance to extinction
   ___d. produces a high rate of responding
   ___e. all of the above
   ___f. none of the above
20. Punishment:
   ___a. is a useful tool in dealing with human behavior
   ___b. should be included in any behavior modification program
   ___c. does not produce undesirable side effects
   ___d. results in permanent loss of punished behavior
   ___e. all of the above
   ___f. none of the above
IV. **Purpose of this Module**

a. The purpose of this learning module is that of presenting a learning package in which students may proceed at their own rate. The content of the module revolves about the notion of habilitation programming. The format of the module is that of programmed instruction in which students are asked to read narratives and to fill in blanks with answers of their own making. With careful reading, it is possible to achieve one hundred per cent accuracy the first time around.

V. **Assumptions of the Module**

a. This module assumes that the learner will be utilizing the knowledge and skills gained in the formulation of the habilitation plan for the residents.

VI. **Motivational Aspects**

a. The result of the learning module is that the experiences gained there from will assist the worker in his everyday job functioning, it will increase his ability to conduct individualized habilitation programming, thus making for a better job experience.
VII. Terminal Objectives

1.0 - The learner is expected to improve his comprehension of habilitation programming as a result of studying the module. To further this end, a pre-test and a post-test are given, with learners encouraged to take each of them.

Specific goals are to teach the learner each of the following:

a. Developing an habilitation plan for the individual resident
b. Strategies and methodologies for habilitation plans:
   1. Introduction to behavioral change techniques within the individual habilitation plan.
   2. Teaching behavioral change techniques within the individual habilitation plan.
   3. Maintaining behavioral change techniques within the individual habilitation plan.

c. Appropriate planning for leisure time activities.
d. Developmental training for the individual.
   1. Basic care skills (social and individual).
   2. Community living skills.
   3. Job-related skills.
   4. Observations and recording (behavioral).

VIII. Enabling Objective

2.0 - The learner will be asked to proceed at his own individual rate in terms of reading the narrative and answering the blank items which appear from time to time. To this end, subject material is presented in different sections by topic. The student's mastery of all topics as they appear is stressed because each topic builds upon the one preceding it.
IX. ATTACHMENTS TO MODULE 3
LEARNING EXPERIENCE ONE

Developing an Habilitation Plan for the Individual Resident

"Habilitation' means the process by which the staff of the institution assists the resident to acquire and maintain those life skills which enable him to cope more effectively with the demands of his own person and of his environment and to raise the level of his physical, mental, social, and vocational efficiency. Habilitation includes, but is not limited to, programs of formal, structured education and training."

"Habilitation' means the process by which the staff of the institution assist the resident to acquire and maintain those skills which enable him to cope more effectively with the demands of his own person and of his environment and to raise the level of his physical, mental, social, and vocational efficiency. Habilitation includes, but is not limited to, programs of formal, structured education and training."

Habilitation refers to all facets of a resident's life. It is not restricted to any single one. This approach does not suggest that concentrating on specific forms of behavior is unimportant.

Both a ___________________________14 and a ___________________________15 approach are necessary in an adequate habilitation plan.

In order to develop an adequate habilitation plan, several steps are necessary. It is important that at least one staff member know the resident well. This staff member should spend as much time as possible getting to know the resident in question. This time should be spent in careful observation, interviewing, and general interaction with the resident.

Staff involved in making an habilitation plan for a resident should spend a great deal of time in ___________________________16, ___________________________17, ___________________________18, and general ___________________________19 with the resident.

Programming refers to a systematic plan for eliminating maladaptive behavior and producing adaptive behavior.

Programming refers to a ___________________________20 for eliminating ___________________________22 behavior and for producing ___________________________23 behavior.
### Learning Experience Two

The staff should know a resident well and should have his best interests at heart. Regular staff meetings concerned with a resident should be held. At these meetings, both the resident’s strengths and weaknesses should be discussed. This double emphasis, upon both the positive and the negative elements of behavior is quite necessary, in order that the total range of the resident’s behavior be looked at.

The staff should ___1___ a resident well and look at both the ___2___ and the ___3___ aspects of his behavior.

It is well to look at categories of behavior in which strengths and weaknesses are observed. These categories are taken from the Ohio Performance Scale (OPI). These categories include behaviors within different areas and different levels of accomplishment within each of the following areas:

1. "Feeding Skills"
   - Bottle feeds
   - East with fork and spoon; carries tray (if applicable), uses knife with help
   - Orders meals in restaurants; uses manners appropriate to situation

2. "Toileting"
   - Wears diapers; requires changing and cleaning
   - Often uses toilet facilities without prompting, has few bowel or bladder accidents
   - Uses public facilities independently

3. "Grooming Skills"
   - Requires dressing by others
   - Baths or showers, using soap, with supervision; washes hands and face with prompting
   - Functions independently in all phases of hygiene

4. "Manual Dexterity"
   - Displays gross movement only
   - Takes large, simple objects apart; puts large objects such as blocks together
   - Displays good dexterity when using hands, e.g., cuts with scissors, threads needles
5. "GROSS MOTOR PERFORMANCE"
   a. Rolls over, but cannot sit
   b. Runs; kicks large ball, throws and catches large ball most of the time using both hands
   c. Displays skill in motor performance; performs skills adequately for participation in most motor activities

6. "PERCEPTUAL SKILLS"
   a. Swallows, sucks, cries; looks at bright or usual objects
   b. Demonstrates awareness of simple cause-effect, means-end relationships, e.g., holds on when swinging
   c. Attends to visual task such as eating while maintaining conversation; responds to subtle sensory cues; anticipates what will happen among actions, objects, events, and people as a spectator

7. "PEER RELATIONSHIPS"
   a. Distinguishes between people and objects
   b. Participates in unsupervised short-term play groups and informal organized activities such as 'hide-and-seek', 'catch', etc.
   c. Increases independent behavior; joins community organizations, e.g., YMCA, church groups

8. "AUTHORITY FIGURES"
   a. Distinguishes between authority figures and peers
   b. Follows directions of three or more steps requiring a delayed time interval for completion, e.g., returns lunch pail to shelf; goes to the restroom and washes hands; joins other children on the playground
   c. Uses authority figures in the community appropriately, e.g., calls the police or fire department, telephone operator

9. "EXPRESSION SKILLS"
   a. Makes sounds of pain, anger, or distress
   b. Says two to six words in meaningful phrases; uses some pronouns; asks simple questions
   c. Talks appropriately with others in various situations

10. "CONCEPTUAL SKILLS"
    a. Makes minimal response to changes in stimuli/situations
    b. Demonstrates comprehension of simple concepts such as gross opposites (e.g., big-little)
    c. Responds appropriately to abstract ideas and relationships such as love, truth, good citizen

11. "READING"
    a. Exhibits minimal response to visual stimuli
    b. Labels objects in picture on request
    c. Reads with some comprehension, general and special materials appropriate for age (e.g., rules, instructions, applications)
12. "WRITING SKILLS"
   a. Attempts to mark on surfaces
   b. Copies or traces pictures or model of own name
   c. Prints or writes to communicate with others (messages, letters, etc.)

13. "TRAVELING ABOUT"
   a. Moves about with aid of vehicle only (wheelchair, walker, scooter, etc.)
   b. Travels to and from places distant from residence in the company of more capable individuals
   c. Uses transportation facilities by self; asks for information, makes arrangements, etc.

14. "LEISURE SKILLS"
   a. Makes minimal attempt to occupy self with equipment
   b. Takes part willingly in games; obeys rules of simple games, e.g., Mother May I?

15. "HOME MAINTENANCE"
   a. Participates minimally in environmental maintenance, e.g., gets out of the way; does not hinder cleaners
   b. Makes own bed, folds and puts away laundry if prompted
   c. Independently and adequately maintains an apartment or personal residence

16. "OCCUPATIONAL SKILLS"
   a. Follows simple commands
   b. Performs many maintenance tasks around residence with some prompting and minimal supervision; does some tasks away from the residence with supervision
   c. Works on a full-time competitive basis; knows some community job resources

17. "PURCHASING"
   a. Looks at items presented
   b. Selects items to be purchased
   c. Purchases wisely; compares quality and prices of like items

18. "USE OF MONEY"
   a. Responds to the presence or absence of things such as food and water
   b. Saves items which can be used to purchase or trade for something else, e.g., points, poker chips, meal ticket or cards
   c. Demonstrates basic economic skills, e.g., pays bills, handles own paycheck, maintains simple budget

19. "HEALTH"
   a. Expresses discomfort, pain, or ill health by gesture or sound
   b. Seeks appropriate personnel for needed medical attention
   c. Cares for own health, e.g., arranges for own medical/dental services, uses community resources
20. "NON-VERBAL COMMUNICATION"
   a. Moves arms, hands, muscles of face
   b. Uses 5 to 10 formal signs of manual language
   c. Exchanges ideas with stranger using manual language

21. "PSYCHOMOTOR"
   a. Self-destructive or severely maladaptive behavior occurs to
      a degree requiring constant supervision or restraint, e.g.,
      bangs head, scratches self, throws things
   b. Has eccentric or unusual behavior(s) that is predictable but
      interferes with programming, e.g., exposing self
   c. Individual has none, very few, or mildly maladaptive habits or
      behavior patterns; essentially demonstrates 'normal' behavior

22. "DELINQUENT"
   a. Violates the customs, rules, laws of society, in a manner which
      requires constant supervision
   b. Leaves residence/place of work without permission, and does not
      return by self; requires pursuit
   c. Is relatively trustworthy and dependable; obeys rules, respects
      property, etc.

23. "AGGRESSIVE"
   a. So physically aggressive, to cause danger to others and/or objects;
      requires nearly constant supervision or restraint
   b. Seldom physically aggressive, often verbally aggressive; abusive
   c. Socially acceptable aggression, e.g., expresses opinions, takes
      criticism

24. "WITHDRAWN"
   a. Totally withdrawn; does not interact with people or objects
   b. Cautious about interaction and participation; timid, interacts
      if encouraged; may withdraw if frustrated
   c. Comfortable in a variety of social situations and interactions

Now that you have read over the various categories and levels within
each category of behavior included within the Ohio Performance Scale, try
to name as many of the categories as you can in the spaces provided below
without looking at the category names given above. Honesty is required for
this task.
Other items are necessary in construction of an individual habilitation plan. These items are suggested by the Ohio Performance Scale. Does the resident require a wheelchair or braces? Are glasses worn? Is a walker, hearing aid, or prosthesis of any description used? Are there severe physical handicaps or behavior problems present? Are there visual, speech, or auditory deficits? Does the resident require medication?

Think of 12 additional items of information which need to be known regarding a particular resident:

An habilitation program needs to specify the degree of assistance the resident requires in each of the twenty categories of behavior specified above. That is to say, is no assistance needed, some assistance, or total assistance. This notion relates to the degree of dependence shown by the resident upon other people to carry out the behavioral objectives listed above. So, for each resident, his performance within each of the categories is rated, and the degree of assistance from others necessary to achieve those objectives is determined.

The result is a specification of the degree to which a resident has achieved behavioral maturity. An habilitation plan specifies several elements, each of which has to do with increasing behavioral maturity.
Increasing behavioral ________37 is the goal of the habilitation plan. This applies to each of the twenty-two categories of behavior specified on the Ohio Performance Scale. In this regard, it is important to list the categories of behavior in which deficits are seen. That is to say it is important to look at problem areas, or areas of behavior in which the resident has some difficulty. Next, it is important to set behavioral goals, or behavior changes which are considered desirable. Third, it is necessary to determine methods for producing the desired behavior change. Fourth, it is necessary to include the date the program is established. Fifth, the date the program is accomplished needs to be recorded. Sixth, the person delivering the behavioral change service needs to be indicated. Seventh, the frequency of the program for behavioral change needs to be shown. Eighth, and finally, the location in which the behavioral change program occurs needs to be indicated.

The eight elements above constitutes the habilitation plan. Each of the elements is a necessary part of the plan. Each resident should have such an individualized plan to meet his/her needs.

The eight elements necessary to an individual habilitation plan are as follows:

38
39
40
41
42
43
44
45

The teacher and students should now discuss what should go into an individual habilitation plan.
LEARNING EXPERIENCE THREE

OBJECTIVE: To discuss strategies and methodologies for habilitation plans with reference to an introduction to behavioral change techniques within the individual habilitation plan.

One of the means for producing behavioral change is known as behavior modification. Behavior modification is a set of techniques based on learning theory developed to assist the behavior change.

Behavior modification is a set of techniques based on _______________1 developed to assist the _______________2 _______________3 _______________4.

Behavior modification has as its goals the elimination of bad or mal-adaptive behavior and the production of good or adaptive behavior.

Behavior modification seeks to produce _______________5 behavior and to eliminate _______________6 behavior.

Two of the most important behavior modification techniques are positive reinforcement and extinction. Positive reinforcement is the increase in frequency of a desirable behavior as a result of application of a positive stimulus or pleasurable event. Extinction is the decrease in frequency of behavior as a result of removal of a positive stimulus or rewarding event.

Two techniques which are frequently used in behavior modification are _______________7 _______________8 and _______________9.

Johnny often gets his way by throwing temper tantrums. In order to stop his tantrums, Johnny's mother rewards him each time he throws a tantrum by giving him a popsicle. To his mother's surprise, Johnny has more tantrums. Johnny's mother has made the mistake of positively reinforcing Johnny's tantrums.

Jennifer's mother would like Jennifer to make her bed every day. However, on those occasions that Jennifer does make her bed, her mother ignores her. This results in a decreased frequency of bed making. Jennifer's mother has extinguished her child's bed making.

Billy throws temper tantrums. Billy's mother ignores them. After a period of this ignoring, the temper tantrums end. This illustrates the techniques of _______________10.

Deborah's mother wants her to make her bed. She gives her a lollipop each time she does so. Deborah's frequency of making her bed increases. This illustrates the technique of _______________11 and _______________12.

Extinction and positive reinforcement are the two main techniques in behavior modification. Two others which you may have heard about are called negative reinforcement and punishment. These will not be discussed here because they often lead to negative emotional reactions and do not work as well
as more positive techniques. Thus the positive approach is emphasized whenever possible in an individual habilitation plan. The positive approach tends to generate favorable emotional responses from the resident and should be used whenever possible.

In general, the principle is to find out what a resident likes to have or to do, and provide for such activities when he or she is behaving appropriately. Such liked things and activities should NOT be provided or allowed when the resident is acting maladaptively.

Criteria or standards for reinforcement should be set up within each of the twenty-two behavioral categories mentioned earlier. Reinforcement should be provided to improve good and not for bad behavior. In general, small behavioral steps should be used. Rome was not built in a day. Large steps may result in frustration in a resident who cannot quite meet the required behavioral standards.

The steps required for reinforcements should be ____________________________13. What a resident _______________14 to do, or to have should serve as reinforcers to be earned for adaptive behavior and not given for _______________15. Adaptive behavior is any behavior that is good, prosocial, or in conformance with the standards of society. Adaptive behavior should be rewarded or reinforced while reinforcers should be withdrawn for maladaptive behavior.

A special technique for use in a progressive habilitation plan is that of shaping successive approximations. In this technique, simpler behaviors are desirable at first and are rewarded. As those simpler behaviors become well learned, the standard for reinforcement increases so that a more complex behavior is required. Whereas Johnny used to receive praise from his mother for helping to make the bed, she now expects him to make it himself. Several steps occur in the process, with Johnny gradually given more and more responsibility for making his bed. Mother was a careful trainer taking care not to expect more from Johnny than he could possibly produce. Consequently, he now makes the bed himself and receives mother’s warm praise. Mother’s training illustrates the process of shaping by successive approximation.

There may be nine steps with respect to a given behavior in an individual habilitation plan. It would do well for a worker to start first with step one and go on to step two only when step one has been thoroughly mastered. Likewise, a similar process should be used for steps three through nine.

Gradually increasing the standard of performance for a particular behavioral task in order to successively approximate a final goal is known as the technique of ____________________________17 by ____________________________18

Discuss elementary behavioral change techniques.
Learning Experience Four

Objective: To teach strategies and methodologies for habilitation plans: Maintaining behavioral change techniques within the individual habilitation plan.

Once change in a behavior has been accomplished, the worker must try to make the change a permanent one. How to go about this is the problem. One way to do this is by the use of intermittent reinforcement. In continuous reinforcement, reinforcement is provided everytime a correct or desired response occurs. In intermittent reinforcement is provided on a schedule. Reinforcement might be given every tenth time a response occurs, this being called a ratio schedule. On the other hand, reinforcement might be given for the first correct response that occurs after a ten minute period has passed, this being called an interval schedule.

Reinforcement which does not occur after each response is said to be on an __________________1 schedule. Within the notion of intermittent reinforcement, there may be either __________________2 or __________________3 schedules.

One advantage of intermittent schedules is that very little reinforcement is needed in order to keep the response occurring. This is a valuable feature especially when there is only a small amount of the reinforcer available.

One advantage of __________________4 is that it requires very little reinforcement to keep the response occurring.

Two important aspects which assist in maintaining behavioral change techniques are immediacy and consistency of reinforcement. Thus, reinforcement should be provided immediately following a response. Reinforcement should also be provided consistently. With intermittent reinforcement, the consistency occurs according to the schedule involved. The resident learns from these aspects that the worker is a model, someone to be looked up to and to be limited.

Two aspects which should accompany reinforcement delivery are __________________5 and __________________6.

Discussion should concern the maintaince of behavioral change techniques.
LEARNING EXPERIENCE FIVE

Objective: To teach appropriate planning for leisure time activities.

Leisure time is very important in the lives of the residents. It is important that such leisure time be structured. That is, leisure time should be planned so that regarding activities can occur.

Leisure time should be ______________________1.

It is important that residents have something to do that is reinforcing. It is helpful if some or target leisure time activities are earned as rewards for having performed socially useful activities during non-leisure periods. Thus, appropriate leisure time activities should be earned.

Some leisure time activities should be ______________________2.

Leisure time should not be boring to the resident. He or she should have enough to do. Cooperative social play is one good means for overcoming boredom and for prompting socially useful ends.

Leisure time should not be ______________________3 to the resident.

It would be helpful to know the resident's likes and dislikes and have on hand a sampling of activities that represent the likes and desires of each resident. This requires that the leisure time activity be planned. Planning should take place so that each resident may become involved in some activity of his or her liking. It would be helpful if such activities serve as rewards for acts done in non-leisure time.

It would be helpful to ________________4 the resident's likes and dislikes. This required that the leisure time activity be ________________5.

Leisure time activities must have a purpose and be rewarding to the resident. Some skills might include eye-hand coordination, arm-leg coordination or some other feature of movement or thought. Most important would be those activities which require some social cooperation from the residents. Team sports are especially good in this regard.

Leisure activity must have a ______________6 and be ______________7 to the residents. Most important would be those activities which teach some ______________8. ______________9 are especially good in this regard.

Discussion should center on the planning of leisure time activities.
LEARNING EXPERIENCE SIX

Objective: To teach developmental training for the individual:
Basic care (social and individual).

The resident’s development as a person is the most important
task of the staff. Initially, before all other tasks, it is necessary
to teach very basic skills. These skills relate to toileting, dressing,
eating, grooming, and basic social interaction.

Five basic skills that are necessary to teach are ______________1,
______________2, ________________3, _______________4 and basic
____________5.

These skills are basic to the development of other skills. It is
necessary that a child or an adult be able to toilet himself, dress him­
self, eat properly, groom himself, and interact socially.

In order to teach these skills, it is necessary to begin training
at the level where the resident is. It is further necessary to proceed
in small steps from that point. Furthermore, it is necessary to provide
reinforcement for achieving small steps or gains.

It is necessary to begin training at the level where the resident
________________6. It is also necessary to proceed in __________7
steps. Furthermore, it is necessary to provide __________8 for
achieving gains.

The worker should make known what he or she expects of the resident
and should assist him or her when necessary. The standard for development
should be very clear to the resident.

The teacher should make ______________9 what he or she expects of the
resident, and should ______________10 him when necessary.

Emphasis should be on what the resident CAN do and not on what he
CANNOT do.

Emphasis should be on what the resident _______________11 do.

The basic self-help skills such as toileting, eating and the like
serve as steps to other skills. They are necessary in order that other
skills may develop.

Discussion should center on the development of basic care skills.
LEARNING EXPERIENCE SEVEN

Objective: To teach community living skills.

Living in the community is the primary task shared by all of us. Social living requires that the self-help skills mentioned in the previous learning experience are well-learned. Furthermore, it requires that social living skills are a part of the resident's routine. In order for this to be so, the resident must be able to respond cooperatively in a social situation.

Community living skills require that the resident must be able to respond ________ 1 in a ________ 2.

The resident must be able to function adequately in groups, sharing what he has learned with others and assisting them in difficult times.

Shaping should be a part of training in community living skills. Emphasis should initially be on teaching social interaction skills. Later, when these skills are learned, emphasis should be on group problem solving skills. Finally, work should emphasize common attitudes and feelings about the community in which the resident lives.

Initial emphasis should be on teaching social ________ 2. Later, emphasis should be on group ________ 4 and ________ 5 skills. Finally, work should emphasize ________ 6 and ________ 7 about the community.

Trial placement in independent living should take place before community placement occurs. The resident should gradually be given more responsibility for himself with training being continued as necessary.

Rules of good citizenship should be taught so that the resident may prove himself a worthy citizen, one who is deserving of the rights of all good citizens everywhere.

_______ 8 placement in independent living should take place. Rules of good ________ 9 should be taught.

Discussion should concern the development of community living skills.
LEARNING EXPERIENCE EIGHT

Objective: To teach job-related skills.

Active vocational training should occur. The resident should be rated so as to determine what vocational skills, if any, he possesses. The job that a resident is assigned to should be related to his or her skills and potential. Counseling should be given regarding what jobs the resident is interested in doing, and concerning what jobs are available. A match should be made between the two. On-the-job training should be given so as to make sure the resident's job performance will be adequate.

Vocational ____________________1 and____________________2 should occur.

The resident should be recognized that retarded residents are often short-changed with respect to their job potential. They are often not hired because employers feel afraid that they cannot perform. It is, however, true that many retarded residents are genuinely motivated to do well on jobs providing, of course, that there is an adequate financial incentive.

Retarded residents are often __________________3 with respect to their job potential. Many retarded residents are often __________________4 to do well.

Samples of work items are often used to rate job potential. These tests should be administered by full qualified technicians. Stress should be placed on gaining cooperation with the resident being tested.

________________5 of work items are often used to assess job potential. __________________6 with the resident should be obtained.

Discussion should proceed regarding the development of job-related skills.
LEARNING EXPERIENCE NINE

Objective: To teach systematic methods of behavioral observation and recording.

A behavioral statement is an objective description of the behavior in which the trainer is interested, along with its antecedents and consequences. An antecedent is an event which precedes the behavior in question, while a consequence is an event which follows it.

Objective description of behavior is known as a _______________1 _______________2. While making objective observations, _______________3 _______________4 _______________5 should be kept in mind.

A time-sampling procedure is the best method of recording behavioral observations.

1. In such a procedure the worker may observe a behavior for 15 minutes, every hour. A check mark on a recording sheet would indicate whether or not a given behavior occurs.

2. The time sampling procedure should also indicate where the resident is during the observation period.

3. The procedure should also indicate what occurs just before the behavior, in order to specify what produces the behavior.

4. Finally, the procedure should indicate what happens following the behavior.

An objective description of behavior along with its antecedents and consequences is known as a _______________6 _______________7. Objective observation of behavior, its location and its antecedents and consequences is known as a _______________8 _______________9 procedure.

Discussion should proceed regarding means of behavioral observation.
Post-Test

Instructions: Each learner is asked to answer all the questions indicated below. There are twenty such questions. Some are of the true or false variety. Others are of a multiple choice nature. Still others require that the best answer be placed in the blank provided. Work as fast and as carefully as possible. If you do not know the correct answer or are uncertain, do not hesitate to guess. Answer these questions honestly without recourse to reference material such as is provided in the text of the module itself. This examination is for self-instruction and is provided for the student's diagnosis of his own knowledge deficiencies. There are twenty questions.

1. Habilitation has nothing to do with teaching life skills to a resident.
   _____ a. true
   _____ b. false

2. Programming is a systematic, planned means of teaching a topic.
   _____ a. true
   _____ b. false

3. Increase in the frequency of behavior as a result of an environmental consequence is known as reinforcement.
   _____ a. true
   _____ b. false

4. Systematic checking and observation of behavior following prescribed time periods has nothing to do with a time-sampling procedure.
   _____ a. true
   _____ b. false
5. Using small steps to reach a certain kind of behavior is known as _______________________.

6. Abilities to toilet, eat, dress and groom are known basic self-help skills.
   ____a. true
   ____b. false

7. Habilitation programming is:
   ____a. for residents only
   ____b. is only for persons with normal intelligence
   ____c. is helpful for normal and retarded residents
   ____d. is useless except in extreme cases
   ____e. all of the above
   ____f. none of the above

8. Habilitation:
   ____a. refers to skills necessary for living
   ____b. suggests a planned approach to teaching living skills
   ____c. is a useful concept in dealing with retarded persons
   ____d. is a necessary concept in program planning for retarded residents
   ____e. all of the above
   ____f. none of the above
9. Proper habilitation requires:
   a. very little planning
   b. much systematic planning
   c. very little in the way of foresight
   d. only one planner in all cases
   e. all of the above
   f. none of the above

10. Teaching from an habilitation plan:
    a. should be done in large steps
    b. places no requirements in the way of the size of the learning step
    c. requires small learning steps
    d. is unnecessary
    e. all of the above
    f. none of the above

11. It is important that following a response:
    a. consistent and immediate consequences occur
    b. consistent consequences occur
    c. immediate consequences occur
    d. consequences occur regardless of whether they are consistent or immediate
    e. all of the above
    f. none of the above
12. Habilitation plans:
   ___a. include social behavior
   ___b. include personal behavior
   ___c. include vocational behavior
   ___d. include educational behavior
   ___e. all of the above
   ___f. none of the above

13. A proper habilitation plan:
   ___a. does not require objectivity
   ___b. does not require a systematic way of looking at behavior
   ___c. does not require specifying behavioral objectives
   ___d. does not specify the means for attaining behavioral objectives
   ___e. all of the above
   ___f. none of the above

14. Habilitation programming is ________________with retarded residents.

15. An increase in frequency of a behavior can be accomplished through
    ________________

16. A useful tool in teaching complex series of behaviors is known as
    ________________

17. Basic self-help skills include ________________, ________________,
    ________________ and ________________. 
18. With retarded residents, it is necessary to teach living skills.

19. Intermittent reinforcement promotes great resistance to ____________.

20. The technique of _______________ produces undesirable side effects.
TREATMENT, SAFETY AND HEALTH PROCEDURES IN RESIDENT CARE
I. PRE-REQUISITES

a. This learning experience requires that you complete modules 1 through 3; or,

b. Have comparable knowledge or experience as demonstrated.
II. DIRECTIONS FOR THE LEARNER

a. You will be tested on your current knowledge of the Treatment, Safety and Health Procedures in Resident Care. There are five parts to Module IV -- they are labeled A through E. When completed, you will be provided with various learning experiences concerning the treatment, safety and health procedures in resident care.

b. Upon completion of the learning experiences, you will again be tested, in order to determine your degree of comprehension.

c. Proceed at your own rate of speed. There are no time limits to this learning module. Notify your supervisor upon completion of the module's activities; he or she will then coordinate the final examination, which will be taken shortly after completion of the module. You will be notified as to the results.

d. Good luck -- enjoy your experience. Please continue with the page labeled "Pre-Test".
TREATMENTS
PRE/POST TEST

1. The most accurate way of taking temperature is:
   a. orally
   b. rectally
   c. axillary
   d. apically
   e. sublingual

2. A normal rectal temperature is: __________

3. Normal pulse range is:
   a. 90-100
   b. 50-70
   c. 60-90
   d. 20-30

4. Insert the thermometer _______ to _________ into the rectum when taking a temperature.

5. A resident’s TPR is checked by an aide who reports the oral temperature is 101.8, pulse is 116, and respirations are 22. Which of the following judgments are correct?
   a. the temperature, pulse, and respiration are normal.
   b. the temperature is above normal, pulse and respiration are normal.
   c. temperature and pulse are normal, respiration below normal.
   d. temperature and pulse above normal, respiration below normal.

6. The most accurate way of checking temperature is:
   a. rectally
   b. orally
   c. axillary
   d. apically
   e. sublingual

7. When respirations are being counted, it is best that the patient:
   a. try to breathe evenly
   b. breathes as deeply as he can
   c. is aware of the counting
   d. is not aware of the counting
8. When a person breathes in and out, this is counted as:
   a. ___ 1 respiration
   b. ___ 2 respirations
   c. ___ 1 expiration
   c. ___ None of the above

9. High blood pressure is called:
   a. ___ hyperglycemia
   b. ___ hypotension
   c. ___ hypertension
   d. ___ hypoglycemia

10. The last sound heard when taking blood pressure is the:
    a. ___ systolic pressure
    b. ___ apical pressure
    c. ___ diastolic pressure
    d. ___ intravenous pressure

11. Blood pressure is measured with an instrument called a:
    a. ___ otoscope
    b. ___ stethoscope
    c. ___ sphygmomanometer
    d. ___ bronchoscope

12. The first sound you hear and take note of in taking blood pressure is:
    a. ___ systolic
    b. ___ apical
    c. ___ diastolic
    d. ___ intravenous
13. The average normal blood pressure is:
   a. ___ 120/80
   b. ___ 100/50
   c. ___ 70/110
   d. ___ 180/100

14. Equipment needed to take a blood pressure is:
   a. ___ stethoscope
   b. ___ watch with a second hand
   c. ___ blood pressure cuff
   d. ___ all of the above
   e. ___ a and c

15. Blood pressure is charted as:
   a. ___ diastolic pressure over systolic pressure
   b. ___ systolic pressure over diastolic pressure
   c. ___ venous pressure over arterial pressure
   d. ___ arterial pressure over venous pressure

16. The equipment needed to take a blood pressure is:
   a. ___ sphygmomanometer
   b. ___ stethoscope
   c. ___ pencil and paper
   d. ___ watch
   e. ___ all of the above
   f. ___ all but d
17. What three observations should be made about the results of an enema?
   1. ____________________________
   2. ____________________________
   3. ________________________________

18. An enema should never be more than __________ above the patients' anus when giving an enema:
   a. ___ 25 inches
   b. ___ 10 inches
   c. ___ 18 inches
   d. ___ 7 inches

19. One reason for inserting a rectal suppository is to ________________.

20. The aide should hold the enema not more than ______ above the patients' anus when giving an enema.
   a. ___ 20 inches
   b. ___ 10 inches
   c. ___ 7 inches
   d. ___ 18 inches

21. The correct temperature for an S.S. enema is ________________.
   a. ___ 125°-130°
   b. ___ 60°-70°
   c. ___ 100°-105°
   d. ___ 50°-55°

22. An oil retention enema is given to:
   a. ___ protect mucous membrane
   b. ___ check local bleeding
   c. ___ soften stool
   d. ___ relieve local irritation
23. When a package of sterile gauze becomes wet, it is:
   a. ____ still sterile
   b. ____ contaminated
   c. ____ not important

24. Ointment is applied to the skin using a ____________.
   a. gauze square         1. ____ a,b,d
   b. tongue blade          2. ____ a,c,d
   c. finger cot            3. ____ b,c,d
   d. disposable glove      4. ____ All of these

25. When instilling eye ointment, how much should the aide use?
   a. ____ particle size of wheat grain
   b. ____ from inner to outer corner
   c. ____ 1 c.c.
   d. ____ 1 capful

26. The temperature of the water in a hot water bottle for an average adult is:
   a. ____ 140 degrees
   b. ____ 120 degrees
   c. ____ 100 degrees

27. Before using the Ambu bag make sure the victim's airway is ____________.

28. Siderails are placed on the residents' beds for the purpose of:
   a. ____ keeping resident from falling from bed
   b. ____ keeping resident from getting out of bed when he is not supposed to
   c. ____ holding bed linen firmly in place
   d. ____ to allow resident support while moving about in bed
29. When pushing a wheelchair down a ramp, the aide should:
   a.  ____ tilt the wheelchair backward
   b.  ____ walk forward with chair in front of her
   c.  ____ walk backward with chair in front of her
   d.  ____ apply brakes

30. The abbreviation "stat" means:
   a.  ____ tomorrow
   b.  ____ at your leisure
   c.  ____ immediately
   d.  ____ after meals

31. The abbreviation P.R.N. means ____________________.

32. A treatment card states the frequency a treatment is to be given as Tid. The aide knows the treatment is to be completed:
   a.  ____ two times per day
   b.  ____ three times per day
   c.  ____ as needed
   d.  ____ any time in day

33. Dry or moist heat is used:
   a.  ____ to aid in healing
   b.  ____ to stimulate circulation
   c.  ____ to ease pain
   d.  ____ all of these

34. The term ambulatory means:
   a.  ____ bedridden
   b.  ____ able to walk
   c.  ____ wheelchair patient
35. The usual number of stools to be checked to make a diagnosis for Amoebiasis is ___________________.

36. Heat, such as in warm, moist compresses, promotes drainage to an area:
   True _________       False ___________

37. The term q3h means:
   a. ___ every three days
   b. ___ every three hours
   c. ___ every hour
   d. ___ every other day

38. Thermometers should stay in Amerse sterilizing solution at least _____ before using again:
   a. ___ 1 hour
   b. ___ 2 minutes
   c. ___ 5 minutes
   d. ___ 10 minutes

39. Instill eye drops:
   a. ___ in upper lid
   b. ___ over the pupil
   c. ___ in lower lid
   d. ___ in any part of the eye

40. Ear drops should be administered:
   a. ___ cold
   b. ___ hot
   c. ___ room temperature
41. When instilling nose drops have the patient:
   a. ___ lying down
   b. ___ sitting up
   c. ___ standing
   d. ___ do them herself

42. The instrument used to look into the eye and examine various structures from front to back:
   a. ___ stethoscope
   b. ___ ophthalmoscope
   c. ___ bronchoscope
   d. ___ telescope

43. A technician skilled in grinding lenses and making glasses:
   a. ___ optometrist
   b. ___ optician
   c. ___ ophthalmologist
   d. ___ obstetrician

44. Each resident should be weighed _______ to provide a record of rapid weight gain or loss.
   a. ___ weekly
   b. ___ monthly
   c. ___ 2 times a week
   d. ___ every 6 months

45. Cold moist compresses are used to:
   a. ___ reduce swelling and discoloration
   b. ___ relieve pain
   c. ___ aid drainage
   d. ___ a and b
   e. ___ all of the above
46. A physician may order the application of cold moist compresses to an area to ________________.
   a. ___ reduce swelling, reduce hemorrhage, and relieve pain
   b. ___ promote healing, aid drainage, and reduce inflammation
   c. ___ relieve pain, aid drainage, and reduce swelling
   d. ___ reduce hemorrhage, aid drainage, and relieve pain

47. Which factors should the aide be aware of in using an ice bag?
   a. ___ place the ice bag in cover
   b. ___ fill bag 3/4 full of large pieces of ice
   c. ___ observe the area for change in skin color q8h
   d. ___ expel air from bag

48. When giving mouth to mouth resuscitation, the first aider breaths into the victim ________________.
   a. ___ once per minute
   b. ___ every twelve seconds
   c. ___ as rapidly as he can
   d. ___ five times per minute

49. A method of introducing a liquid diet directly into the stomach per a tube which has been inserted thru surgery:
   a. ___ gavage
   b. ___ gastrostomy
   c. ___ intravenous
   d. ___ subcuraneous
IX. DEMONSTRATIONS
DEMONSTRATIONS (VIDEOTAPE) WILL OCCUR IN THE FOLLOWING:

1. TPR
2. Blood Pressure (BP)
3. Enema - Suppository
4. Ointments
5. Drops: eye, nose, ear
6. Ace Bandage
7. Hot/Cold Compresses
PERSONAL CARE OF RESIDENTS

MODULE IV-B
1. When giving a tub or shower bath the water controls should be adjusted by:
   A. ____ the working resident
   B. ____ the aide
   C. ____ the supervisor

2. Discontinue alcohol sponge bath if resident develops:
   A. ____ a high temperature
   B. ____ pain in head
   C. ____ cyanosis or weak pulse

3. When the resident is being bathed it is a good time to check him for ______

4. The purpose of a sitz bath may be:
   A. ____ to relieve painful joints
   B. ____ to soak feet
   C. ____ to relieve painful hemorrhoids

5. A slab bath is good to use to bath:
   A. ____ a total care resident
   B. ____ a hyperactive resident
   C. ____ a resident when there is no one to assist you

6. When using the whirlpool tub always:
   A. ____ fill tub up to the top
   B. ____ secure resident in chair with a belt
   C. ____ run agitator 10 minutes

7. A whirlpool should run no longer than:
   A. ____ 1 minute
   B. ____ 5 minutes
   C. ____ 30 minutes
   D. ____ 15 minutes
8. The correct temperature of water used in the whirlpool bath is:
   A. ___ 85° - 95°
   B. ___ 100° - 105°
   C. ___ 75° - 80°
   D. ___ 99° - 100°

9. When bathing a resident, the aide should:
   A. ___ supervise the bath
   B. ___ fill the tub with water before the resident enters the tub
   C. ___ check temperature of water

10. Cutting the corners of your toenails down may encourage _________________.

11. Fingernails and toenails should be cut:
    A. ___ every two weeks
    B. ___ once a month
    C. ___ when needed
    D. ___ upon doctor's approval

12. A normal toenail should be cut:
    A. ___ in an oval shape
    B. ___ straight across with mild rounding of the sharp corners
    C. ___ using cuticle scissors
    D. ___ by podiatrist

13. The best time to trim nails is _________________.

14. The diabetic resident should have his toenails trimmed by the podiatrist because:
    A. ___ his nails are thick
    B. ___ any cuts may be difficult to heal
    C. ___ his feet are very sensitive to pressure
15. List three (3) precautions to observe in giving a shampoo.
   1. __________________
   2. __________________
   3. __________________

16. When applying ointment to the skin use:
   A. ___ tongue blade
   B. ___ gauze square or glove
   C. ___ bare finger

17. The most important reason for washing your hands is:

18. To avoid irritation of the skin during the bath, it is best to use:
   A. ___ only medicated soap
   B. ___ no soap
   C. ___ rinse skin well
   D. ___ use cold water

19. The most important procedure in keeping feet healthy is to keep them ______
    ________________.

20. Oral hygiene should be given to residents:
   A. ___ when the mouth is dry
   B. ___ twice daily
   C. ___ only after bathing
   D. ___ after breakfast and supper

21. The resident must be ________________ when shaving.

22. All razors should be ________________ in a central area when not being used
    for shaving.
23. Do not use ___________ blades to shave a resident.

24. The best position for teaching drinking from a cup is:
   A. ____ head tilted toward ceiling
   B. ____ head tilted to one side
   C. ____ head tilted slightly downward
   D. ____ none of these

25. When feeding or giving a resident a drink the resident should:
   A. ____ Be supported and raised to normal position for swallowing
   B. ____ Be flat in bed so liquid can run down
   C. ____ It really doesn't matter as people swallow regardless of position
   D. ____ Be placed on his side, so food he can't swallow will run out the side of his mouth

26. Residents clothing should be marked with first then last name.
   A. ____ True
   B. ____ False

27. When considering toilet training of a resident, which of the following statements is true?
   A. ____ Girls take longer to train than boys
   B. ____ The resident should be punished for accidents
   C. ____ The training must be done on a consistent basis
   D. ____ None of the above

28. All residents clothing should be properly __________________________.

29. Woolen clothing such as coats, suits, sweaters, etc... must be checked and "aired" to prevent ______________________damage.

30. Woolen clothing should not be sent to the ______________________.

31. Home, or Personal Fund Clothing should not be worn by other ____________.
32. If food is eaten too fast, there is more danger of the resident ______________.

33. Eating skills such as chewing, swallowing and sucking are important to the development of speech.
   A. ___ True
   B. ___ False

34. Encourage residents to take food from a spoon with their ___________ not their teeth.

35. To increase lip control necessary for feeding, ___________ games may be helpful.
   A. ___ relay
   B. ___ blowing
   C. ___ quiet
   D. ___ circle

36. Give one reason why it is important to try to teach appropriate mealtime behavior to the resident.

________________________________________________________________________
________________________________________________________________________

37. Why is it important to brush residents' teeth after meals?

________________________________________________________________________
________________________________________________________________________
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<tr>
<th>TYPE</th>
<th>PURPOSE</th>
<th>SAFETY MEASURES</th>
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<tbody>
<tr>
<td><strong>Shower bath</strong></td>
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<tr>
<td></td>
<td>1. to promote cleanliness</td>
<td>1. area free from drafts.</td>
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<td></td>
<td>2. to promote comfort</td>
<td>2. Place rubber-mat on shower floor.</td>
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<td></td>
<td>a. place chair or rubber mat if resident's is weak or unable to stand.</td>
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<td>3. to remove perspiration from the skin</td>
<td>3. Never adjust the water controls when resident is in the shower.</td>
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<td>4. Allow resident to bathe himself; help only when needed.</td>
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<td>5. Never leave resident alone.</td>
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<td>6. Avoid unnecessary exposure.</td>
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<td>7. Observe resident's body for burns, rashes, abrasions, blisters, sores, swellings or growths.</td>
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<tr>
<td><strong>Bed bath</strong></td>
<td>1. to cleanse and refresh</td>
<td>1. Have room comfortably warm.</td>
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<td>2. Fill basin two-thirds full with water.</td>
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<td>3. Test temperature by placing inner side of wrist into basin.</td>
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<td>4. Encourage resident to assist in his own bath, if able to do so.</td>
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<td>5. Wash eyes before using soap.</td>
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<td>6. Then wash arms and hands, dry thoroughly</td>
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<td>7. Bathe chest, then abdomen.</td>
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<td>8. Have resident flex knee - then bathe thigh and leg farthest from you.</td>
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<td>9. Wash neck and back, then buttocks, then genitals.</td>
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<td></td>
<td>10. Comb hair.</td>
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<td></td>
<td></td>
<td>11. Cut and clean nails.</td>
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</table>
### Tub Bath

1. Fill tub one-half full of warm water 96°F. temperature comfortable to wrist.
2. Assist with bathing if necessary.
3. Rinse tub, scour tub and rinse again.
4. Place soiled linen in laundry hamper.
5. Leave bathroom clean and in order.

### Slab tub

1. Temperature of gauge should be set at 95° - 100°.
2. Room warm and free from drafts.
3. As resident is transported to bathing cart, covered with sheet and safety strap secured. A team of two or more people lift up.
4. While resident is being bathed, the mattress is washed.
5. Wash eyes before using soap.
6. Bathing face, neck, ears, etc...
7. Resident is removed to cart, dried, powder applied and resident dressed and placed in bed.
8. Comb resident's hair.
9. Check that safety side rails are up.
10. Clean tub and pad thoroughly.

### Whirlpool

1. Place chair in position at Saf-lift: Be sure that safety belt is fastened.
2. Resident is lifted to desired height (limit of weight for Saf-Lift is 350 lbs).
3. Fill tub to about 1 inch above opening or from wall of tub.
4. Water temperature 85° - 95° before resident is lowered into tub.
5. Rotate chair into position over tub.
6. Time of whirlpool action should not exceed 5 minutes.
7. Whirlpool must be used only with a physician's order.

8. Rinse tub, scour well, rinse tub again, dry.
NAIL CARE PROCEDURE

PURPOSE:

To trim finger and toe nails.

To maintain healthy nails.

To prevent disfigurement of nails.

EQUIPMENT:

1. Finger nail clippers
2. Toe nail clippers
3. Basin with warm water
4. Towel
5. Nail file or emery board

INSTRUCTIONS:

1. To soften nails for easier trimming, soak nails in warm water for approximately 5 - 10 minutes or trim nails immediately after bathing.

2. Trim nails straight across. Use nail file or emery board to round corners and clean under nails.

3. Trim residents nails every 1 to 2 weeks or as needed.

4. If resident is a diabetic, careful inspection of hands and feet daily can prevent serious infections and ulcers.

The diabetic resident can be sent to the Podiatry Clinic with an appointment for trimming of toenails.
SHAMPOOING OF HAIR

PURPOSE:
To cleanse hair and scalp
Shampoo weekly unless patient is ill.

PROCEDURE:
1. Before shampooing get all necessary items.
2. Check scalp for irritations.
3. Brush hair thoroughly.
4. Wet hair thoroughly.
5. Apply soap or shampoo and develop a thick lather.
6. Rinse hair thoroughly.
7. Apply soap or shampoo a second time.
8. Rinse thoroughly.
9. Place towel around the hair and press surplus water from the hair.
10. Place all used towels in laundry hamper and put soap or shampoo in proper places.

KEY POINT:
1. Comb, brush, soap, or shampoo and towels.
2. If any are noticed, report this to physician.
3. Brushing loosens dandruff and stimulates scalp.
4. Using warm water.
5. Let water flow over your own hand to make sure it doesn't get too hot. Adjust accordingly.
6. Repeat No. 5 procedure.
7. Hair will have a squeaky feel when it is rinsed thoroughly.
8. Comb and dress the hair as desired.
ORAL HYGIENE

PURPOSE:
To cleanse the teeth and mouth
To maintain a healthy oral activity
To help restore normal condition of diseased oral cavity

EQUIPMENT:

a. Routine Mouth Care:
   - Cup
   - Emesis basin
   - Mouth wash (Cepacol, 1/2 strength Hydrogen Peroxide, or plain water)
   - Towel
   - Toothbrush (well labeled)
   - Toothpaste
   - Denture powder and denture cup for cleaning artificial dentures

b. Special Mouth Care:
   - Gauze sponges
   - Tongue blades
   - Applicators
   - Two medium cups
   - Paper bag
   - Solution as ordered

General Instructions:

1. If dentures are to be left out of the resident's mouth temporarily or for a long time, they are to be placed in a denture cup in water and kept in a safe place to prevent breakage.

2. Special mouth care is a nursing procedure indicated in the care of all acutely ill or unconscious residents and should be given at least every three (3) hours, after every meal and after a resident vomits.

3. Solutions which may be used in giving special mouth care are:
   a. Scordes solution: Lemon juice ¼ oz.
      Glycerine ¼ oz.
      Water ¼ oz.
   b. One part hydrogen peroxide to one part tap water.
   c. Diluted cepacol

4. If patient is unable to open mouth, press down slightly on chin.
If facial or oral surgery is done, check physician's order for procedure to follow.
Oral Hygiene: continued

5. Suctioning may be necessary to remove excess secretion and solutions from mouth. Do not pour solution into the mouth of an unconscious resident.

6. Wash hands and explain procedure to resident.

Procedure for Routine Mouth Care:

1. Place resident in sitting position or turn resident to side with side of residents face along edge of pillow and over towel.

2. Pour mouth wash into paper cup and dilute with an equal amount of water.

3. Moisten toothbrush over emesis basin and pour a little mouth wash on it. Apply dentifrice.

4. Hold emesis basin under chin or (at side of face of resident if resident cannot sit up).

5. Brush teeth or instruct or assist resident in brushing teeth. Brush teeth beginning at gum and moving to edge of teeth.

6. Rinse mouth with mouth wash solution.

7. Rinse toothbrush under running water at lavatory.

8. Rinse emesis basin with cold water, follow with warm water and soap, rinse with hot water, dry.

9. Return emesis basin and toothbrush to bedside table.

Procedure for Care of Dentures:

1. Have resident remove dentures or use tissue wipes or gauze to remove them and place in curved basin.

2. Use toothbrush and dentifrice to brush dentures holding over curved basin partially filled with water. Handle carefully.

3. Rinse dentures well and place in denture cup filled with fresh water.

4. Have resident rinse mouth with water or mouth wash solution.

5. Replace dentures.
Procedure for Special Mouth Care:

1. Use towel to protect linen.

2. Instruct or assist resident to turn to side, place curved basin along cheek.

3. Use soft bristle brush and dentifrice if resident cooperates.

4. If resident has dry crusting, moisten swabs or applicators with hydrogen peroxide and gently cleanse the gums, tongue, lips and inner surface of the cheeks. Use applicator to cleanse around the teeth.

5. If not crusting, use mouth wash solution.

6. Then cleanse area with Sordes or other prescribed solution. Use a fresh swab for each application.

7. Discard used swabs and applicators in paper bag or paper towel.

8. Allow resident to rinse mouth with mouth wash if he is able.

9. For excessive dryness, may apply small quantity of mineral oil to lips and inside mouth.

CHART:

1. Type of treatment
2. Kind of solution
3. Time and date
4. Condition of mouth, if abnormal
5. Any unusual reactions of resident
6. Report anything unusual or abnormal to Nurse if in hospital or Matron if in cottage.
Shaving

Most men feel and look untidy if they are unable to shave every day. It is the duty of the Psyche Aide to shave Residents daily or make sure they do it themselves. A Resident with an unsteady hand, poor eyesight, mental depression or severe mental retardation should not be allowed to shave himself. If it is safe, allow the Resident to shave himself because he should be encouraged to be as independent as possible. You may get the equipment ready for him, make him comfortable and provide a mirror and a good light.

The razors are kept locked, in a central area when not in use and are not to be used by the Resident without supervision because of the potential danger of the razor blades. This rule applies to both safety and electric razors.

Be sure the razor is sharp-- dull blades make shaving a painful process. Always use plenty of lather and shave in the direction of the hairs, holding the skin taut. Be careful not to nick the skin--broken skin provides an avenue for infection.

Equipment needed for shaving with a safety razor is:

- Basin of hot water
- Shaving brush
- Shaving soap or cream
- Safety razor
- After shave lotion or powder

Place a light so no shadows fail on his face. Put the safety razor together tightly and use a sharp blade. Use plenty of lather to soften the hairs; hold the razor at an angle of about 250 degrees; use short firm strokes; hold the skin taut. Wipe the hairs and lather from the razor frequently. Shave carefully around the nose and lips--these areas are especially sensitive; wash the face to remove the soap. Lotion and powder are soothing, however some men may not like to use them. If the skin is nicked, apply an antiseptic and cover with a sterile dressing.

You may have occasion to remove facial hair from some of the women. This helps to make them more attractive. The same principles of shaving would apply.

Also axilla hair should be shaved at intervals to make washing easier and deoderent more effective.

Where electric razors are available they provide a easier and safer method of shaving both men and women.

When new supplies are needed notify the Matron. Supplies come from the store room and are State supplied or charged to individuals. Families may bring shaving supplies or they may be gifts.
TOILET TRAINING THE RETARDED CHILD

Steps to Follow

I. READINESS

A. Resident. The Resident has to be physically and mentally ready for toilet training to be successful. Some signs of readiness are:

1. Regularity of bowel movements. Bowel training precedes bladder training.

2. Regularity of urination. Should stay dry for longer periods of time (around 2 hours).

3. Shows discomfort after soiling himself. May be fussy or take clothes off.

4. Signs of readiness. He lets you know verbally or nonverbally (tugging at clothes) when he has to go to the bathroom.

5. Begin training when you are ready to invest time and patience. Training a resident takes more time and more patience.

6. Keep a record for 3-5 days. This will give a pattern of regular time of elimination.

II. PLACE

A. Resident. If a small toilet chair is used, it should be placed in the bathroom, not to be carried from room to room. This will help your child know the correct place and reason for pulling down his pants.

B. The transfer to a regular seat can be made later when the resident has learned bladder and bowel control.

C. Talk about what you are doing, step by step. Stay with the resident if he shows fear. Avoid giving him toys. These may distract him from the task at hand.

D. If urination is expected, pouring warm water over the perineum or penis may help produce results.

E. Help resident to realize the elimination came from him. If he succeeds, show him your pride. Let the resident observe other members using the bathroom.
III. CLOTHES

A. Your resident should wear training pants - not diapers. This is a psychological motivation and the resident is not an infant - "puddles" should not annoy you.

B. Clothing should be easy to pull up and down. Resident's should not wear overalls or clothes that are difficult to disassemble and reassemble.

IV. APPROACH, TIME AND SEQUENCE

A. Teach resident to say "I have to go to the bathroom," or just "bathroom". Use of other words can be embarrassing when in public. Use the same word each time.

B. Lead your resident gently and calmly into the bathroom.

C. Smile and say "Down comes __________'s pants and up _______ goes". Stay with your resident because, if he should urinate or have a bowel movement, reward him immediately. Remember, the reward should be something he likes - cookies, raisins, a hug, a kiss, etc. However, if after 5 minutes nothing happens, remove your resident calmly and gently from the toilet.

D. Then use a sequence of saying, "Now off ______ comes; Wipe yourself". Then say, "Up go __________'s pants".

E. Remember, at first your resident should be placed on the toilet every hour for no more than five minutes at a time. This is done because of the probability of your resident voiding some time during the day when he is on the toilet. Thus permitting you to reward the appropriate behavior. This will help the resident form an association between voiding in the toilet and something pleasant happening to him when he does. He will want to do it again.

F. It helps to note the time your resident usually has a bowel movement and put him on before it happens. Reward immediately by having the reward available.

G. If the resident resists the training (cries or screams), delay the program.

V. KEY FACTORS FOR YOU TO REMEMBER

1. Reward immediately for voiding in toilet.
2. Patience
3. Consistency
4. Timing
5. Self control
6. Tender Loving Care (TLC)
CHART FOR CHECKING TOILETING

<table>
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<tr>
<th>Monday</th>
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Keep chart for one week to see the times that the child voids and also the times he has a B.M. Then see the pattern. Exam: Perhaps he voids more often at certain times, such as 9 a.m., 1 p.m., 5 p.m., 8 p.m. Then take those times to put him on the toilet. If you catch him, praise him. Remember this will take at least two to three weeks of faithful follow-through. Good luck.
GENERAL INSTRUCTIONS:

1. All residents’ clothing should be properly marked.
2. Clothing must be kept clean by washing or dry cleaning (see Dry Cleaning Procedure).
3. Clothing should be properly stored in areas usually called “Clothes Rooms or Wardrobes”.
   A- Each resident has one or more clothes boxes for his or her clothing, another for shoes.
   B- Coats, suits, etc. are on wooden hangers with name or number of resident.
4. Woollen clothing such as coats, suits, sweaters, etc. which are on hangers or racks, must be checked and aired to prevent moth damage.
5. Clothing should be kept in good condition, missing buttons replaced, torn places mended.
6. Woollen clothing should not be sent to the laundry.
7. Home, or Personal Fund Clothing should not be worn by other residents.
8. Clothing tags to separate individual residents’ clothing on racks are available in the storeroom.

PROCEDURE FOR ORDERING CLOTHING:

1. Inventory periodically to determine needs. Order as need arises.
2. Coats and boots should be ordered in July. Shorts and swimsuits should be ordered in January.
3. Measure correctly, refer to procedure on measuring. C-21
4. Specify-Adult or children sizes.
   Clothing Forms AM-38 for Males, and AM-39 for Females, will be used for all orders.
   State, Home, Social Security, Veterans, Sewing Room Orders. They will be marked accordingly.
5. Make two (2) copies, one to remain in the Cottage and one to be sent to the Clothing Supervisors Office.

HOME ORDERS:

1. Clothing requests will be sent to the family from the Clothing Supervisors Office.
2. When you receive clothing from home, try the clothing on resident to make sure clothes fit properly.
   Record in Receipt book and record on Visi-record.
   Send Receipt card to family locating items received, by mail or direct.
   This should be done before clothes are sent to the Marking Room.
3. If clothing does not fit properly, do not send clothing to the Marking Room.
   Contact the Clothing Supervisor so the items can be returned. If parent visit frequently, the clothes may be given to them to exchange for the proper size.
4. See that all items are marked properly.
SOCIAL SECURITY, VETERANS, RAILROAD PENSIONS ORDERS. (PERSONAL FUNDS ORDERS)

1. A representative from a local department store is here every Tuesday. Orders are sent in every week and returned the next week.
2. When you receive the clothing order, try on and check for proper fit. If clothing does not fit, contact your clothing supervisor immediately so the clothing can be exchanged the following week for the proper size.
3. Record and describe on Visi-record.
4. See that all items are properly marked.

STATE ORDERS:
1. When compiling orders for State residents from AM-38 or AM-39, the Storeroom Requisition Form #400-62 will be used.
2. Compile the order by grouping like items of the same size from the individual state order Form AM-38 or AM-39, and totaling the same.
3. Keds, Dress Shoes, Work Shoes must be ordered on a separate Requisition #400-62. These will not be marked in the Marking Room. Shoes will be marked in the cottage after they have been tried on resident for proper fit. These shoe orders will be initialed by the Cottage Coordinator.
4. If is not necessary to fill in the "ON HAND" column of the Storeroom Requisition form #400-62.
5. When ordering clothing for incontinent residents, or for a cottage (such as, 4 dozen overalls, size 42 for Cottage X), the storeroom Requisition form #400-62 must be filled out, also forms AM-38 and AM-39, instead of residents name, it should read General Use-Class X.

SEWING ROOM ORDERS:
1. Dining room uniform for female residents working in dining room.
2. Measurements needed for the uniforms; Bust, waist, back waist length and skirt length. Blouses are not made at sewing room. Blouses are ordered from General Storeroom. Cottage completes form for Sewing Room Clothing. (Contact Staff Development for this Sewing Room Clothing form).

MARKING ROOM PROCEDURE:
1. Make clothing slip in three (3) copies (AM-38, AM-39).
   (a) Print residents name, cottage, and class number in capital letters (spell name correctly). No nicknames.
   (b) Mark in number of each item you are sending. Check and be sure you have the count correct.
2. Tie each residents clothing together with two (2) copies of AM-38 or AM-39 clothing slip on the outside of the bundle. (one copy remains in cottage).
3. Clothing must be properly bundled with correct spelling of resident's name on clothing slip.
4. Name should be printed in capital letters with first name first, then second name, as example (ROBERT JONES). Do not use initials or nicknames.
MARKING ROOM PROCEDURE CONTINUED:

5. Mark clothing slips of "New Residents" as such, clothing will then receive priority in the Marking Rooms.
6. State supplied socks for male and female residents may be marked for cottage only.
7. Home and Residents own fund supplied socks must be marked for Resident.
8. Place individual bundles in a laundry bag, label it "Marking Room".

RE-MARKING OF CLOTHING:

1. For residents being transferred within the Institution, remarking for the same resident, or if clothing is to be marked for someone else; use the above procedure but make a note on the clothing slip (AM-38 or AM-39) explaining to Marking Room. If a resident is being transferred from one cottage to another, the cottage that transfers the resident is responsible to send the clothes to the Marking Room. They will phone the cottage the resident is being transferred to and ask how they are to be marked. Shoes, suitcases, belts, etc... will be sent with the resident.

DRY CLEANING:

1. Dry cleaning will be sent to General Storeroom on the 2nd and 4th Wednesday of each month.
2. Two (2) copies of a Male AM-38 or Female AM-33 requisition will be filled out, listing each item that is to be dry cleaned.
3. When cottage receives a green copy of the receiving report from the General Storeroom, they will know that the Dry Cleaning is ready to be picked up.
4. The Supervisor or Charge of the cottage will make a Storeroom Requisition (#600-62) listing all of the dry cleaning goods, and give it to the cottage coordinator for signing approval. After it is signed by Cottage Coordinator it is sent to business office to be signed by Business Manager for issue.
5. Then the Dry cleaning may be picked up at the storeroom.

DISPOSITION OF CLOTHES:

1. Worn out clothes should be condemned by the Unit Supervisor.
2. These worn out clothes should be placed in laundry bag, tagged as "CONDEMNED" Clothes and have Unit Supervisor sign the tag.
3. Phone 297 when they have been approved by the Unit Supervisor, to have them picked up for disposal.

HOME AND SOCIAL SECURITY (OWN FUNDS) CLOTHES:

1. When resident expires, a list of his or her clothing and personal items should be sent to Superintendents Office, c/o Mrs. Frances Follrod. These items should be held until notified as to what the relatives wishes to do with them. Cottage will be notified. Use Form MN-200-Page D-11 in Procedure Book.
2. Resident clothes too small: If a resident outgrows his or her clothing, they must remain in cottage until the family is notified about these clothes. A list of these clothes should be sent to the Clothing Supervisor. The cottage will be notifies as what to do with the clothes.
CLOTHING CARE:

Sewing Room Orders: (Item made in Sewing Room only)

1. When compiling orders for state residents from Form AM-38 or AM-39, the Storeroom Requisition Form #400-62 will be used.

2. Compile the order by grouping like items of the same size from the individual state order (form AM-39 or AM-38) and totaling the same.

3. It is not necessary to fill in the "On Hand" column of the Storeroom Requisition Form #400-62.

4. When ordering clothing for untidy residents or for cottage (such as: 4 dozen infirmary suits, size 44 for Cottage X), the storeroom requisition form is all that is necessary to fill out. Fill in the on hand column on this requisition.

5. Measurements needed for the following articles:

   No. H-1 Regular print dresses - bust, waist, hips, and dress length.

   No. H-2 Heavy duty dresses - bust, waist, hips, and dress length.

   No. - 3 Infirmary suits - bust, waist, hips and back of neck to middle of crotch.

   No. - 4 Uniforms - bust, waist, back waist length and skirt length.

Blouses are not made in the sewing room. This will require a separate requisition following the above procedure for State Orders.
MEALTIME PROCEDURES:

Points to remember:
1. Make mealtime as pleasant an experience as possible.
2. Relax the resident. Both swallowing and chewing are easier this way.
3. Rushing a resident through a meal is not good policy. Not only could it create choking, but it makes it difficult for a resident to eat.
4. Do not make a resident eat something he/she does not like.
5. The amount of time per meal is based upon the type of food being eaten.
6. Encourage the resident to feed himself/herself.
7. Develop the resident's ability to use eating utensils.
8. Encourage good eating skills. Discourage eating with fingers.

DEVELOPING FEEDING SKILLS:

I. Why develop feeding skills?

A. Advantages to resident:
   1. Individual who must be fed benefits physically from correct oral patterns; also safer for him.
   2. Increased independence and feeling of accomplishment.
   3. Eating skills are essential to development of speech - biting, chewing, sucking, swallowing and lip movement.
   4. Self-feeding individual is more socially acceptable. (easier to include in outings, home visits).

B. Advantages to Staff:
   1. Mealtime could be less stressful and rushed if resident were easier to feed or were self-feeders.
   2. Staff would have more time and energy available for planning and carrying out other training or activation programs which would develop residents further in other areas.

II. General Guidelines:

A. Before concentrating on specific oral problems, get resident's posture and position as normal as possible.
1. Upright or as upright as possible for resident. (May be a gradual process).

2. A chair is better than a lap for all except the smallest infants. (To achieve more personal contact, may hold his hand).

3. Avoid supporting head with your hand at back of his head; causes him to push back. The base of the skull below the ears is OK; top of the head is best.

4. Elbows should be supported even with top of table or tray.

5. Feet should be flat on floor or supported in incorrect position and alignment; shoes may improve positioning.

6. Use props as necessary to maintain alignment.

B. Feeder/trainer may sit in front of or beside individual, but must avoid standing and leaning over him. Sit at level of resident or lower.

C. Feed in relaxed, unhurried manner. Interact with the resident, rather than being distracted by ward activity and conversation.

D. Hold spoon level with resident's mouth. Teach and wait for him to bring head forward to reach the food.

III.

A. Bites down on spoon or spoon handle.

1. Avoid putting entire spoon within dental arch.

2. If he has clamped down, flex head slightly forward and wait until spoon releases. Do not pull it out or try to force jaw open; soft plastic spoon may be used to prevent damage to teeth but those do tend to crack and splinter with forceful clamping. Can try the rubber coated spoon.

B. Tongue thrusts beyond teeth. This movement of the tongue may have the purpose of keeping food out of the windpipe. Most residents who have this pattern are mouth breathers and do not use their soft palate to close the nasal passages as food moves back.

1. Place food in mouth from front or side with firm downward pressure as food is left on tongue.

2. Avoid tip of tongue; use mid-tongue.

3. May place food at side of mouth so tongue does not push it out.

4. Find rhythm of feeding that meshes with his breathing and swallowing patterns.

5. To overcome tongue thrust, individual must learn to swallow with mouth closed.
C. Does not swallow readily

1. Stroke throat

2. Position more upright to enhance swallowing

3. Lack of swallowing may be voluntary; deliberate response to being fed too quickly. Slow down and tell resident to swallow praising him when he does.

4. Be sure to look and listen for swallowing. Food may be going down without actual swallowing.

5. Milk, sweet drinks and citric juices cause increase mucous, making swallowing more difficult. Salty and oily liquids thin mucous making swallowing easier.

D. Does not use tongue

1. Place food in alternating sides of mouth.

2. To teach him to push tip of tongue out past lips and curl up past lips as in licking lips, put sticky food on upper lip and get him to lick it off. (Peanut butter, honey, etc).

IV. Teaching drinking

A. Problem: Letting fluids run to the back of the mouth by gravity, to be reflexively gulped, will never teach voluntary tongue and throat movements or swallowing. It forces the resident to eat in an abnormal pattern and prevents development of more advanced skills.

B. Teaching skills

1. Use liquids you know resident enjoys. If child has swallowing problem avoid melted ice cream and milk as this will increase mucous and make swallowing more difficult. Avoid tart juices - may cough and be irritating.

2. To teach swallowing, flex head slightly (downward). Have enough liquid in cup so that head doesn't have to be extended to sip it, yet not so full that it may spill.

3. During normal drinking of liquids, the side of the cup is pressed against the lower lip while the tip of the tongue moves freely in the cup or mouth. The tongue should not be under the edge of the cup. However, if resident has tongue thrust, pressure on the tongue and lower lip with the side of a plastic cup is helpful. Give small amount of liquid, then release pressure and wait for swallowing to occur.

4. Lip closure - is important; Once liquid is in mouth it is easier to swallow if lips are closed. Press finger downward on chin to help close jaw.
5. Should not bite cup - wait if he does.
6. Do not give more sips until has swallowed the last one.
7. If resident gets stiff and tense when cup is put on his lips, stop and wait until he is relaxed. Should be made as pleasant and relaxing an experience as possible.

V. Teaching Chewing

A. Advantages
   1. Necessary for better speech development.
   2. Improves health of gums, teeth and supportive tissues.
   3. Diet can be more varied and in a more healthful form; bulk can be included.

B. Vital to provide reason for chewing thru diet. Activate lips and tongue as well as chewing with semi-solid or chopped foods.

C. Methods
   1. Place food between teeth on side of mouth.
   2. Demonstrate chewing motions.
   3. Encourage lip closure during chewing.

D. Rotary chewing is the goal - adult pattern of using jaw and teeth

VI. Teaching Self-feeding

A. In any individual who has the range of motion which allows him to bring his hand to his mouth and who doesn't have oral musculature problems can be taught to feed himself.

B. If a resident is not a self-feeder, staff should make it a habit to feed him with the staff member's hand placed over the resident's hand. Very few residents should or must be passively uninvolved in being fed.

C. Readiness
   1. Ability to pick up and retain objects in hand-toys, finger foods.
   2. Ability to bring hand to mouth - with objects.
   3. Ability to remove food from spoon with mouth.
   4. Ability to maintain grasp on spoon or substitute for grasp, such as spoon taped to hand.
   5. Good head and trunk control are advantages, but not essential in every case.
6. Adequate appetite so that feeding process is motivating to resident.

D. Progression of learning
   1. If resident accepts solid chewable foods, finger feeding would proceed spoon feeding.
   2. Bringing spoon to mouth and removing food.
   3. Returning spoon to tray for more food.
   4. Dipping.

E. More advances skills: can be taught using shaping and fading
   1. Avoid spilling.
   2. Drinking liquids independently.
   4. Use of knife and fork.
   5. Family style eating: passing dishes, dishing up own food, spreading butter on bread.
   6. Social skills and manners.
      a. making requests
      b. using napkins
      c. putting on over bib

Demonstrations Follow in the Areas Below:
   a. Positioning while eating.
   b. Teaching the resident to learn to suck.
   c. Teaching the resident to learn to swallow
   d. Self-Drinking skills.
   e. Chewing skills.
   f. Teaching a resident to eat solid foods.
   g. Teaching your resident to use correct eating utensils.
Observing, Reporting, Prevention and Treatment of Unusual Body Conditions.

Module IV-C
1. Give two symptoms of possible disease in a resident that should be reported to the cottage physician:
   1. ______________________
   2. ______________________

2. Give one reason why you should report unusual symptoms in a resident to the cottage physician ____________________________________________________________

3. Name two observations of unusual skin conditions that should be called to the attention of the cottage physician:
   1. ______________________
   2. ______________________

4. Swelling of the tissue due to an accumulation of fluids is:
   A. ____ Dyspnea
   B. ____ Edema
   C. ____ Hemorrhage

5. Which of the following are symptoms of shock?
   A. rapid weak pulse
   B. rapid strong pulse
   C. warm and dry skin
   D. moist and cool skin
   1. ____ A,C
   2. ____ A,D
   3. ____ B,C
   4. ____ B,D

6. Constipation may be caused by:
   A. ____ inactivity
   B. ____ too soft, bland diet
   C. ____ inadequate fluid intake
   D. ____ all of the above
7. Chemical burns are treated by:
   A. ______ treating for shock
   B. ______ flush area with large amounts of water
   C. ______ apply an ointment
   D. ______ apply dressing to area

8. Severe loss of fluid through fever, vomiting and diarrhea produces a physical state known as:
   ______ A-Hepatitis
   ______ B-Gastritis
   ______ C-Dehydration

9. An injury caused by scraping or rubbing:
   ______ A-Aggression
   ______ B-Abrasion
   ______ C-Anemia

10. Vital signs include:
    A. ______ color of skin
    B. ______ Blood pressure, temperature, pulse, respiration
    C. ______ nausea
    D. ______ size of pupils

11. A contracture is _______________.
    A. ______ a muscle
    B. ______ bed-sore
    C. ______ fixed joint
    D. ______ type of skin irritation
12. To avoid a serious accident when getting a resident into a wheelchair, the aide must be sure that:
   A. ____ the back of the wheelchair is padded with a pillow
   B. ____ the wheels are locked and the foot rests are folded up out of the way.
   C. ____ the wheelchair is safe by sitting in it before placing resident in wheelchair.

13. A pressure sore can be caused by _______________ in the same position for too long a time.

14. When a non-ambulatory resident is sitting in a chair their feet should be supported.
   A. ____ True
   B. ____ False

15. Proper positioning of the resident helps to prevent:
   A. ____ Contractures
   B. ____ Seizures

16. Decubitus ulcers or bed sores:
   1. are caused by continuous pressure
   2. occur when a patient lies for a long period of time in one position
   3. they are hereditary
   4. can be prevented by relieving pressure, stimulating circulation, keeping the skin dry.
      A. ____1,2 & 3
      B. ____1,2 & 4
      C. ____1,3 & 4
      D. ____all of the above

17. Which of the following is not a recommended treatment for decubitus ulcers?
   A. ____ allowing resident to remain in one position
   B. ____ protecting boney prominences with sheepskin, pads, rubber rings or doughnuts.
   C. ____ Keep skin clean and dry around areas
   D. ____ Applying light massage
18. A person who is choking cannot speak or ________ and turns _________.

19. When respirations are being counted it is best that the resident:
   A. ___ try to breathe evenly
   B. ___ is not aware of the counting
   C. ___ breathes as deeply as he can

20. The term cyanosis means:
   A. ___ Toxic condition
   B. ___ Rash on the skin
   C. ___ A blue color as applied to the skin

21. In the Heimlich Maneuver, foreign material is forced out of the air passage by a quick upward thrust on the victims:
   A. ___ chest
   B. ___ upper abdomen
   C. ___ lower abdomen

22. First aid for poisoning by mouth includes:
   A. ___ induce vomiting
   B. ___ dilute poison with water or milk
   C. ___ observe victim for symptoms of poisoning
   D. ___ call doctor if victim becomes unconscious

23. The first step an aide should perform to control bleeding from a deep laceration is?
   A. ___ direct pressure and elevation
   B. ___ tourniquet
   C. ___ apply dressing
   D. ___ apply pressure to pressure point

24. To control bleeding, the first step a first aider should take is:
   A. ___ to apply a tourniquet
   B. ___ to apply direct pressure to the site of bleeding
C. ____ to apply pressure to pressure point
D. ____ to apply ice pack to site of injury

25. A sterile dressing is placed on a wound:
A. ____ to keep wound from becoming infected
B. ____ absorbs drainage
C. ____ protects wound from further injury
D. ____ all of the above

26. Which of the following are symptoms of diabetes?
A. ____ polydypsia, polyuria, polyphagia
B. ____ loss of weight, acetone breath
C. ____ increased sugar in blood
D. ____ all of the above

27. To control bleeding what two things may be necessary to do?
1. ________________________________________________
2. ________________________________________________

28. Involuntary passage of the urine is called:
A. ____ Cystitis
B. ____ Gastritis
C. ____ Incontinence
D. ____ Ureters

29. Diabetes mellitus:
A. ____ is hereditary
B. ____ is not hereditary

30. A resident in diabetic coma will have:
A. ____ Pale, moist, cool skin
B. ____ Symptoms of shock and high blood sugar
C. _____ Drowsiness, flushed, hot, dry skin, fruity odor on breath

31. Insulin is manufactured in the:
   A. _____ Liver
   B. _____ Gall bladder
   C. _____ Pancreas

32. A common and serious complication of diabetes is:
   A. _____ heart disease
   B. _____ jaundice
   C. _____ infection
   D. _____ high blood pressure

33. A resident displays symptoms of excessive thirst, frequent urination, increased appetite and sweet odor of breath. The aide would remember these symptoms of:
   A. _____ Epilepsy
   B. _____ Diabetes mellitus
   C. _____ Amebiasis
   D. _____ Hepatitis

34. What would you do for a resident who is having a seizure?

35. Which of the following would the aide not do while attending a resident having a grand mal seizure?
   A. _____ loosen clothing around neck
   B. _____ hold resident's head to one side
   C. _____ restrain resident's movements
   D. _____ move furniture from immediate area

36. Seizures that are characterized by severe muscle contractures of the entire body and unconsciousness is what type?
   A. _____ petit mal
   B. _____ grand mal
   C. _____ psychomotor
37. In caring for a seizure victim name two important precautions you would take:
   1. _______________________________________________________
   2. _______________________________________________________

38. A momentary warning to the resident just before a seizure occurs:
   A. ____ coma
   B. ____ aura
   C. ____ aroma
   D. ____ anecdote

39. A resident fell during a seizure striking his head on the floor. The aide should beware of which symptoms that may indicate a head injury:
   A. ____ pupils unequal in size
   B. ____ vomiting
   C. ____ bleeding from nose, ear canal, or mouth
   D. ____ blood in urine
   E. ____ A, B, C
   F. ____ A, B, D,
   G. ____ B, C, D
   H. ____ all of the above
IX. READING MATERIALS
SIGNS AND SYMPTOMS OF DISEASE

In order to give our residents better medical care, it is important to recognize disease in an early stage, so that proper treatment may be carried out. Many disease conditions are easily and completely curable when treatment is begun early; on the other hand, cure may be impossible or partial if the disease is allowed to go on for weeks or months.

All persons who are in constant contact with the residents have the responsibility of calling attention to the first signs of physical disorders. By close observation, especially during baths, meal-time, recreation periods, etc., you may be able to recognize signs of disease in your residents.

Below are listed some of the common symptoms which should be called to the unit physician's attention:

1. General Body Symptoms
   - Weight loss without dieting
   - Rapid weight gain
   - Loss of appetite
   - Increase thirst
   - Dizziness
   - Weakness
   - Shaking, chills
   - Frequent or severe headache
   - Swelling in any part of the body
   - Lumps or sores on any part of the body
   - Pain or injury
   - Dehydration

2. Vital Signs (TPR & B/P)
   - Temperature elevation
   - Low Temperature
   - Weak, thready pulse
   - Irregular pulse
   - Fast or slow pulse
   - Shallow or deep respirations
   - Noisy respirations
   - Difficulty in breathing

3. Skin
   - Bluish or yellowish in color
   - Rash
   - Open sores
   - Pale skin or red skin
   - Bruises
4. **Eyes**

- Redness of eyes or eyelids
- Swelling of eyes
- Discharge or profuse tearing
- Foreign body in eye (if it is imbedded)
- Yellow color in white part of eye
- Clouding of eyes
- Styies
- Crust above edge of eyelids
- Signs of blindness (running into things, falls, feeling things)

5. **Ears**

- Discharge or bleeding
- Pain in ear or back of ear
- Foreign body in ear (do not attempt to remove)
- Profuse hardened ear wax
- Signs of deafness

6. **Nose**

- Chronic discharge
- Runny nose (not chronic)
- Sneezing
- Repeated nosebleeds
- Foreign body in nose
- Injuries to nose

7. **Mouth**

- Tongue - coated, red, pale, swelling, ulcer
- Teeth - sharp, broken, toothache
- Gums - swelling, ulcer
- Sores that do not heal
- Difficulty in swallowing
- Swollen or discolored lips
- Rash or red mouth
- Sore throat

8. **Neck**

- Swelling or lumps in neck
- Stiffness or pain in neck

9. **Chest**

- Chronic cough
- Coughing up blood or pus
- Shortness of breath or difficulty in breathing
- Any pain in chest
- Lumps in breast or under the arm
10. **Abdomen**
   - Any swelling or lump in the abdomen or groin
   - Nausea or vomiting
   - Pain in abdomen
   - Rigid abdomen

11. **Rectum**
   - Hemorrhoids
   - Bleeding or drainage from rectum
   - Abnormal bowel movements (blood, mucus, worms, diarrhea, fluid)
   - Chronic constipation

12. **Genitals and Urine**
   - Swelling
   - Redness
   - Discharge
   - Itching
   - Abnormal color or odor of urine
   - Pain or difficulty in urinating

13. **Arms and legs**
   - Swelling or pain
   - Deformities
   - Lumps
   - Paralysis or weakness
   - Varicose veins

14. **Feet**
   - Swelling, pain
   - Corns or bunions
   - Callouses
   - Ingrown toenails
   - Deformities

15. **Mental State**
   - Coma or semicomatose
   - Confusion or disorientation (not usual with resident)
   - Drowsiness or stupor
   - Chronic tiredness
   - Agitated
   - Sudden change in usual behavior
Heimlich Maneuver
Real Lifesaver
To Choking Victims

WHAT TO LOOK FOR

1. Choking Spasm

2. Tongue and Teeth

3. Collapses

HEIMLICH, DIRECTOR of surgery at The Jewish Hospital, Cincinnati, and head of the hospital's esophageal center, the only one in the country, and has a 30 year background in medical and surgical management of esophageal and swallowing problems.

On Feb. 21, he will head an 11 member group at Children's Hospital in Columbus to demonstrate his method for emergency squad members and hospital personnel.

When a person is choking so that the airway in his throat is blocked, he is unable to speak, gradually turns blue, and soon collapses. If it is not possible to reach into the back of the throat and extract the food with your fingers, Heimlich advises his procedure is in order.

THESE ARE THE METHODS:

1. If the victim is standing or sitting, stand behind him, wrap your arms around his waist, and allow your head, arms, and upper torso to hang forward, grasp your fist with your other hand and place the fist

against the victim's sternum, slightly above the navel and below the rib cage. Press your fist forward into the victim's stomach with a quick upward thrust. Repeat if necessary.

2. If the victim is lying on his back, kneel astride his hips, facing him. With one of your hands over the other, place the heel of your bottom hand on the abdomen just above the navel and press the rib cage into the victim's sternum with a quick upward thrust. Repeat as needed.

IN BOTH METHODS, Heimlich explains, pressure forces the diaphragm upward, compresses the lungs, and expels the blocking object from the breathing passage.

If the victim is above 14, Heimlich may apply the same pressure with his hand to the back of a collar.
HEIMLICH MANEUVER

When the victim is sitting, the rescuer stands behind the victim’s chair and performs the maneuver in the same manner.

1. Stand behind the victim and hold your arms around the waist.
2. Allow his head, arms, and upper torso to hang forward.
3. Grasp your fist with your other hand and place the fist against the victim’s abdomen, slightly above the navel and below the rib cage.
4. Place your fist forcefully into the victim’s abdomen with a quick upward thrust.
5. Repeat several times if necessary.

1. Stand in front of the victim and hold your arms around the waist.
2. Allow his head, arms, and upper torso to hang forward.
3. Grasp your fist with your other hand and place the fist against the victim’s abdomen, slightly above the navel and below the rib cage.
4. Place your fist forcefully into the victim’s abdomen with a quick upward thrust.
5. Repeat several times if necessary.

1. Grasp your fist with your other hand and place the fist against the victim’s abdomen, slightly above the navel and below the rib cage.
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2. Place your fist forcefully into the victim’s abdomen with a quick upward thrust.
3. Repeat several times if necessary.
DIABETES - MELLITUS

Small patches of tissue in the Pancreas, the islets of Langerhans secrete the hormone - INSULIN, which regulates the amount of sugar in the blood. If these cells secrete too little insulin, sugar accumulates, which the kidneys attempt to eliminate in the urine. (Called Diabetes Mellitus).

Diabetes Mellitus is controlled by doses of insulin, but, if left untreated, it can be the cause for serious damage or death.

1. Diabetic Clinic -
   Young and old housewives
   Business Executives
   Teachers, secretaries, children, etc.
   Most would be women (more women than men)

Insulin discovered in 1921 by Sir Frederick Banting and Dr. Charles Best (Revolutionized treatment of Diabetes)

Diabetics can lead normal lives if they follow what their doctors tell them to do.

2. What is Diabetes?

   Diabetes Mellitus is a condition which develops when the body is unable to change sugars and starches into energy or cannot store them in the body.

   Peculiar relationship between carbohydrates and fats, so that interference with carbohydrate metabolism results in a fat disturbance also.

   Fats not burned completely form Ketone Bodies (acids) and they use up the alkali reserve of the body, causing serious difficulty. The pancreas secretes insulin which is necessary to make these changes. If it is lacking or the body is unable to use it properly, sugar piles up in the blood and spills over into the urine. The Island of Langerhans are the specific cell group in the pancreas that secrete insulin. Damage of these cells is one cause of Diabetes, although not the only one. Researchers are working steadily to find out more about the interference with the use of sugar in the body.

   One thing certain, the symptoms of Diabetes disappear when insulin is given to a diabetic.

3. Who gets Diabetes?

   Some people more likely than others to develop diabetes. Children and young people do have it but, most diabetics are older. It seems to affect more married than single women, this may be due to endocrine changes or gain in weight during pregnancy. Older people are usually over-weight when Diabetes is discovered.

   History of a person with diabetes usually proves that some person in his family has had it, this indicates heredity plays a part. This does not mean a person shouldn't marry but, it does indicate that if two diabetics...
marr, their children will have more diabetic tendencies. Pregnancy of a diabetic woman should be under careful medical supervision.

4. Symptoms -

Many people have Diabetes and do not know it. The condition may develop so gradually that no symptoms are noticeable. In the body of the untreated Diabetic sugar is gradually accumulating in the blood, and the kidneys are making a strenuous effort to get rid of the excess sugar through the urine (the presence of sugar in the urine is called GLYCOSURIA). Eventually, signs of these efforts appear as POLYUOPSIS, extreme thirst and POLYURIA, excess urination. Also, because the diabetic is not getting the benefit of his food (carbohydrate) he has Polyphagia, increased appetite. These are the outstanding symptoms in untreated diabetics. Other symptoms are fatigue, loss of weight and a tendency to infections, especially in the skin and the extremities. Middle age and older diabetics are often over-weight; frequently they also have some form of blood-vessel damage which makes itself evident as high blood pressure, kidney trouble or tiny hemorrhages in the retina of the eye. Sometimes, diabetics have aches and pains that are quite severe.

5. Tests for Diabetics

Sometimes diabetic learns about his condition for the first time through a urine check, which shows sugar. However, this can be an indication of other conditions so that tests are made to determine the amount of sugar in the blood and to find out how able the body is to handle the sugar.

Test given - Glucose Tolerance

1. Specimen of blood and urine taken
2. Fasting resident given sugar in form of glucose
3. Samples of blood and urine at 1-2-3 hours depending on order of physician
4. Resident fasts until test is completed.

Your responsibility to the resident having the test is to:

a) See that they don't have food during fasting period
b) To save and label properly - urine specimens
c) To see that blood samples are drawn by laboratory

A test used after a person is found to have sugar is a FASTING BLOOD SUGAR, This is blood drawn in the morning before breakfast and tested for the amount of sugar content.

6. The control of Diabetes -

Although seldom cured, it can be controlled if the individual will cooperate. Young people rapidly become worse if treatment is neglected. After the age 40, diabetes progresses slowly but, an infection can greatly hasten the progress of the disease.
Diabetes is under control when the resident is:

a) at his proper weight
b) has a very little sugar in urine
c) has a safe level of blood sugar
d) has no symptoms

The object of treatment is to help him lead as normal a life as possible and to keep him at his normal weight. Some diabetics can be controlled by diet or oral medications if their case is mild enough.

No children are given oral medication, it has been found in most incidents that they can be controlled better by insulin injections.

7. Insulin

Severe diabetes cannot be controlled by diet alone or oral medications; the body also must have insulin to regulate its use of sugar. The dosage of insulin is determined by the physician according to the amount of excess sugar found in the blood and urine.

Insulin is manufactured mostly from the pancreas of a hog or cow. There are different types of insulin and people react differently to particular insulins.

Regular
Crystalline Protamine Zinc
Globin Lent
NPH (Discuss units, U40-U80, insulin syringe)

The dose of insulin is regulated by the individual diabetics condition. Oral medication is called Hypoglycemic agents and is not the same as insulin.

Nursing care of Diabetic in Procedure Book

Hypoglycemia
Hyperglycemia
EPILEPSY

Epilepsy is a Greek word meaning a "seizure or to be seized", and was conferred by a famous Arabian physician, Avicenna, in the Fourteenth Century A.D., and perpetuates the notion that the sudden convulsions and unconsciousness were the work of some sinister agency. Epilepsy has always been known as a mysterious disease and called by many names such as the "falling sickness" or "sacred disease". In 460 B.C. Hippocrates finally interpreted the terrifying symptoms in terms of a natural disease. He described it as a disorder due to afflictions of the brain. For the next 2,000 years, the study of epilepsy stood stagnant as other studies of medicine. The moon was regarded as the special guardian of epilepsy. Convulsions were explained by diabolical possession and witchcraft.

With the 17th century, much advancement was made in the scientific modern medicine.

In 1925, Dr. Hans Berger, a German psychiatrist, developed the electroencephalograph (EEG) which created a landmark in the history of epilepsy. In 1934 he demonstrated that the cerebral disturbance in epilepsy was accomplished by characteristic changes in the normal electrical activity of the brain.

The cause of epilepsy is mainly idiopathic or unknown. However, a variety of genetically determined conditions are associated with epileptic seizures.

Convulsions may occur after brain damage acquired in prenatal, natal or postnatal periods. Neurologic examination of such children frequently shows a motor handicap of the central nervous system, origin (cerebral palsy) and mental retardation. Seizures themselves do not produce mental retardation.

The recognition of genetically determined conditions is important for several reasons:

1. Cerebral damage in younger brothers and sisters of affected residents may be prevented in certain instances by prompt and effective treatment.

2. Less characteristic signs and symptoms in siblings may be more readily recognized; and

3. Identification of an organic cause of the seizure is important in determining treatment and possible outcome of the condition.

In general, control of such seizures and social adjustment of the child is far more difficult than the child with idiopathic form.

Epilepsy is a temporary loss of consciousness accompanied by twitching of the muscles, sometimes so severe that they are convulsions. Unconsciousness may last anywhere from a moment to 15 minutes or more.

Scientists have found that the electric waves given off by the brains of epileptics follow a different pattern from those of most healthy persons. People with those "different" brain waves seem to be susceptible to epilepsy.
Head injuries, brain infections, body disturbances, or emotional upsets can bring on epileptic seizures in these people.

Most epileptics begin to have seizures before they are 20, and the most common age is in the first 2 years of life.

There are different types of seizures:

**Grand mal seizures** -

Generalized severe convulsions, with loss of consciousness. Usually there is an aura, which is a warning of the impending attack, (halo, bright light, cry out, abdominal pain) but quite often the convulsion follows so rapidly that the victim has no time to prepare for it. The convulsion begins with a cry and the resident falls heavily to the floor. At first in the tonic phase, the body is perfectly rigid - all muscles are in a tight spasm. He becomes cyanotic, since he is not breathing. In about 15 seconds, the convulsive or clonic stage begins. All the muscles in the body alternately contract and relax, usually very violently. This may continue for 1 to 3 minutes. The saliva in his mouth appears foamy around his lips and his tongue may be bitten if it falls between his teeth. The resident may remain unconscious for a few minutes or even hours; he may regain consciousness but not know that he has had an attack. He may be incontinent, confused, nauseated or complain of headaches. A grand mal seizure may occur at night without the resident being aware of it. A bitten tongue; lip; headache; blood on pillow; or a bed wet with urine may be the only clues.

**Petit mal seizures** -

Involves only a momentary loss of consciousness after which the resident resumes his normal behavior. Minor manifestations such as an upward rolling of the head or slight quivering of the trunk and limb muscles might be present. These attacks usually last only 30 seconds and are most frequently described as "dizzy spells" or "lapses". The resident rarely falls but usually drops articles which he may have in his hand. This kind of seizure varies in frequency from 1 to 2 a month or as many as several hundred a day.

**Jacksonian or focal seizures** -

The resident may or may not lose consciousness. In most cases he does not. Certain groups of muscles or the entire body may be involved. The seizures start out as a jerking or a feeling of numbness which creeps upward from the hand or foot. (Caused by brain tumor or lesion.)

**Psychomotor seizures** -

Characterized by trance-like states and episodes of confusion. It is much more common in adults. The resident is not unconscious but has no memory of the episode. Other episodic but sustained moods may be in the form of extreme irritability, depression, ill humor, or bad temper. In some instances, these automatisms assume the nature of fugues which is a state of amnesia, of considerable duration, during which the resident appears to act in a conscious way, but after recovery has no remembrance of the state.
The acts of violence committed in these automatisms are often of a strikingly brutal nature. The resident pursuing his crime to a revolting extreme. Grand mal seizures may be associated with these seizures. Usually they continue for only a few minutes, but they may go on for hours or even days. Their frequency increases with age.

Epilepsia cursiva or "running fit" is also included among the psychomotor epilepsies. This is an episodic alteration of awareness associated with running. Consciousness may be clouded and the resident usually has grand mal seizures along with this entity. The duration of running is brief. Frequently one finds a history of conflicts with members of the family that seem to have acted as precipitating factors.

Care during a seizure includes:

1. Let resident be where he falls, until seizure is over.
2. Loosen clothing around neck.
3. Do not pry open jaw, if clamped.
4. Place an object between the resident's teeth.
5. Hold resident's head to one side so that saliva can run out.
6. Do not restrain resident's movements forcefully.
7. Do not give fluids until fully conscious.

Care after seizure includes:

1. Examine resident's body for injuries.
2. Place him in bed and permit him to sleep.

Observations should include:

1. Did the resident appear confused, or show any unusual behavior before the seizure?
2. Did he cry out?
3. Were there both clonic and tonic and tonic spasms, and how long did they last?
4. What was the rate of pulse and respiration?
5. Did his face and lips become blue?
6. Did he bite his tongue or lips?
7. Did he froth at the mouth?
8. Did the pupils react to light, contract, or dilate?
9. Were there any bruises or injury?
10. How long was he conscious?

11. How long did he sleep after seizure?

12. What were his complaints upon awakening?

The epileptic should lead as normal a life as possible and get adequate rest and exercise. He should avoid driving and automobile, bicycle, or ride a horse, or climb to any height. He should not operate exposed machinery because of the danger of falling into it during an attack. He should also not participate in boxing or football because of the danger of brain damage. Never should an epileptic swim alone.

Fewer seizures seem to occur if the resident is mildly dehydrated due to less cerebral edema. Therefore a well balanced diet with avoidance of excess food and fluids should be provided.

Anti-convulsion drugs are highly effective in cutting down the number of seizures. They include Phenobarbital (sedative effect), Dilantin (anti-spasmodic effect), Tridione (used in petit mal seizures), and Masantoin (helpful to grand mal seizures. When attacks resistant to Dilantin).

All attacks should be observed and recorded - the time it occurred, severity, the resident’s physical appearance during and following an attack.

The resident should sleep on a bed with sidemaps or a low bed so that a fall to the floor would not cause severe injury.

Epileptic residents under ideal situations such as quiet, nonstimulating environment where they are made to feel content and secure are much less apt to develop seizures. These persons should be encouraged to carry on with normal activities.

Progress has been made in the medical treatment and control of epilepsy but the attitudes of society toward the child with epilepsy have not kept in pace. This will come through the education of the public - only then will the epileptic child lead a completely normal life. There are about 1,000,000 persons in the U.S. with epilepsy. (Roughly one out of nine).
Discussion Items

1) Digestive irregularities
2) Bleeding
3) Choking
4) Proper Positioning of Resident
CLASSNOTES FOR PRONE, SUPINE, AND SIDELYING

I. Definition of Positioning

Placing a resident in a position in bed or in a wheelchair which is as comfortable and as therapeutic as possible.

II. Why it is Important

A. Prevents severe contractures and trunk deformities from developing
B. Gives resident a chance to view environment from different perspectives
C. Gives resident a chance to develop his potential in motor development
D. Prevents possible skin breakdown.

III. Guidelines

A. Position should be comfortable for resident
B. Position should allow for present deformities which aren't reversible
   1. Extremely tight hip flexors
   2. Extremely tight knee flexors
C. Position should reduce deformities which are somewhat correctible.
   1. Scoliosis
   2. Kyphosis
   3. Lordosis
   4. Tight adductors
D. Position should normalize tone whenever possible
   1. Extensor spasticity-attempt to flex
   2. Flexor spasticity-attempt to extend
E. Position should lead to skills whenever possible
   1. Prone to gain head control
   2. Sidelying to bring arms to midline.

IV. Special Problems - General rules which apply:

A. Strong ATNR
   1. Position semi-sidelying
   2. Position prone with head turned to non-dominant side
B. Extreme hip and knee flexion contractures
   1. Position prone as much as tolerated
   2. Position supine with drawsheet pulling legs into extension

C. Adductor contractures
   1. Pillow between legs in semi-sidelying
   2. Pillow between legs in prone (support ankles)

D. Dislocated hip
   1. Semi-sidelying on unaffected side (neutral rotation and abduction)
   2. Prone
      In case of bilateral dislocated hips prone and semi-sidelying on either side with a pad under trunk to keep pressure off of the hip.

E. Dislocated shoulder
   1. Semi-sidelying (keep arm forward)
   2. Prone (pillow under chest to keep shoulder forward)

F. Back Deformities
   1. Kyphosis - prone or supine with total body extension
   2. Lordosis - prone or supine with total body flexion
   3. S-curve scoliosis - prone or semi-sidelying to either side
   4. C-curve scoliosis - prone or (most often) semi-sidelying to convex side
      a. Prone
      b. Semi-sidelying - correctable on either side
         uncorrectable - converse side
**BASIC BED OR MAT POSITIONING**

**PRONE:**

1. Pillow lengthwise under head and upper trunk; arms are placed around the pillow.
2. Pillow crosswise under lower trunk and hips—ensure that the lower edge of the pillow ends at the hip joint.
3. Pillow or bolster between the entire length of legs to obtain maximum abduction.
4. Rolled diaper pad under each ankle to prevent toes from touching the bed or mat.

**SEMI-SIDELYING:**

1. Pillow behind entire trunk and hips; prop the pillow up against the bed railing or the wall.
2. Folded diaper pad under head; the pad should not extend past the face to prevent resident from lying in his saliva.
3. Pillow or bolster between the entire length of legs to obtain maximum abduction. Prop up end of the pillow so that the ankles are not least as far apart as the knees.
4. Sandbag in front of trunk to prevent resident from rolling forward.

**SUPINE:** (Only for residents with extension patterns)

1. Pillow under head to encourage neck flexion.
2. Pillow under knees to decrease lumbar curve.
3. Pillow or bolster between entire length of legs to obtain maximum abduction.
4. Rolled diaper pad under shoulders to support them.
ADVANTAGES AND DISADVANTAGES OF PRONE, SUPINE AND SEMI-SIDELYING

PRONE - ADVANTAGES
1. Enables resident to work toward good head control
2. Leads to higher motor skills i.e., puppy position, rolling, crawling.
3. Aids in inhibiting abdominal breathing

SUPINE - ADVANTAGES
1. Breathing unobstructed
2. Good for kyphosis or lordosis if properly positioned

SEMI-SIDELYING ADVANTAGES
1. Easier to get arms and head to midline
2. Helps "round out" flattened chest
3. Helps decrease scoliosis if positioned correctly
4. Decreases influence of ATNR if positioned properly

PRONE DISADVANTAGES
1. Adaptive equipment, i.e., bolsters may be misused resulting in chest deformities
2. Tight healcords may result if feet are not watched
3. Resident may have trouble breathing if he has no protective turning of head
4. Gavage and gastro tubes may be obstructed

SUPINE DISADVANTAGES
1. Flattens chest and encourages abdominal breathing
2. ATNR is strongest
3. Increase excessive extensor tone
4. Doesn't encourage child to gain good head control or higher motor skills

SEMI-SIDELYING DISADVANTAGES
1. Resident often difficult to keep in this position
2. May increase scoliosis if improperly positioned
3. May increase hip and knee flexion contractures
4. If incorrectly positioned, may develop skin breakdowns on bony prominences

Use as many of the above positions as possible for your residents
Residents should be turned on an average of every 2 hours
Individual tolerances must be considered
BASIC CHAIR POSITIONING

A. Place child in the chair with the hips back as far as possible; secure with hip restraints.
B. Head maintained in midline.
C. Footrest is adjusted so that knees are flexed to at least 30° and the feet are maintained in neutral position.
D. Place diaper roll between legs from diaper to the feet to obtain maximum abduction.
E. Place tray on chair.
F. Place rolled blanket on tray with the arms up and over the roll.
BASIC POSITION IN STANDING

1. a) The standingbox's upper edge should be at the resident's chest level. The resident's height in the box is corrected by means of an adjustable foot support in the box. In case the resident's trunk control increases the upper edge of the standingbox can be at a lower level.

   b) The resident should not be capable of turning around in the box and if enough room is available for him to do so a pillow must be placed between his back and the backplate of the box. There is no adjustment made of the upright position of the box, which is true vertical.

2. The legs should be placed slightly apart with staff using a bolster between the legs, if necessary.

3. The knees should be straight. If the resident has insufficient muscle tone or control to accomplish this, apply posterior plaster splints with ace bandages.

4. Feet should be flat on the floor or foot support. Shoes should always be worn for support; orthopedic shoes being necessary where deformities are present.

5. Trunk and head should be erect and kept in midline.
1. Amoebiasis most commonly affects the ____________________.
   a. ___ Liver
   b. ___ Stomach
   c. ___ Large intestines

2. A diagnosis of amoebiasis is made thru a microscopic examination of ____________.
   a. ___ blood
   b. ___ urine
   c. ___ stool
   d. ___ vomitus

3. What part of the body is affected most by amoebiasis?
   a. ___ pancreas
   b. ___ liver
   c. ___ large intestine
   d. ___ heart

4. Amoebiasis is found in the stool of an infected person and spread by contaminated hands, food and dishes.
   True ________ False ________

5. Diagnosis of Amoebiasis is made by examination of the:
   a. ___ blood
   b. ___ urine
   c. ___ stool

6. Hepatitis is a viral infection of the:
   a. ___ gall bladder
   b. ___ large intestines
   c. ___ liver
7. Symptoms of pediculosis are:
   a. ___ itching
   b. ___ blisters
   c. ___ conjunctivitis
   d. ___ runny nose

8. Pediculosis is usually transmitted by:
   a. ___ personal contact
   b. ___ hats, combs, brushes
   c. ___ bed linen
   d. ___ All of the above

9. Residents are checked for lice or parasites:
   a. ___ when they return from vacation
   b. ___ when they show signs of itching
   c. ___ when they are first admitted
   d. ___ all of the above

10. Head lice (Pediculosis capitus) can be transmitted by: ____________________.

11. Cyanotic means ________________.
    a. ___ bluish color
    b. ___ faint
    c. ___ mental attitude
    d. ___ rash

12. The most effective procedure you can do to avoid spreading infections is: ____________________.
IX. READINGS
Amebiasis or Amebic Dysentery

Amebiasis is an acute or chronic disease caused by a protozoan parasite, Entamoeba histolytica, and characterized by diarrhea with blood stained mucus.

SYMPTOMS:

Acute amebic dysentery. Sudden onset with malaise (general discomfort or feeling of un-wellness), headache or chill, followed by mild or severe abdominal pain. There may be nausea and vomiting. Diarrhea appears quickly. Frequent watery stools, containing mucus, blood, and shreds of intestinal mucosa are passed with or without straining.

Abdominal distension, soreness and tenderness are present.

Dehydration and prostration may be present where the case is severe and frequent bowel movements are present. In this case the temperature may be slightly elevated.

Chronic amebic dysentery - the acute stage may go into the chronic stage. May not show specific symptoms - usually fatigue easily and complain of tiredness and weakness. Appetite poor with repeated mild or severe attacks of colic or diarrhea with blood and mucus. Weight loss may be present. Signs and symptoms of liver or lung abscess may be present. Lowered resistance to secondary infection is characteristic. Carbuncles, multiple furunculosis, and nail infections are frequent and respond sluggishly to usual treatments till amebiasis is recognized and treated.

METHOD OF TRANSMISSION:

The disease is spread by water contaminated by infected stools, by food contaminated by human carriers or flies. Acute cases do not spread the disease until convalescence sets in and cysts are found in the stool.

RECOGNITION:

The disease is recognized by the clinical signs and by examination of the stools which will reveal the ameba or cysts. (Ameba has two forms - vegetative and encysted.) Then cysts are swallowed they pass through stomach unchanged, but their coverings are dissolved in the human intestines and the vegetative forms are released. These are passed to large intestine where they may cause ulceration. They multiply in ulcers and if diarrhea is present are passed out of body in the stool. If diarrhea is not present, they multiply and become encysted. (The passage of the encysted ameba by the convalescent person is the source of infection).

COLLECTION OF STOOL:

1. Examination must be made while the specimen is warm and fresh as the vegetative form disintegrates quickly.

2. Urine, soap, antiseptics kill ameba quickly; specimens taken after oil enemas are unsatisfactory. Saline enemas may be used.

3. Several stools must be obtained as the ameba appear only intermittently in the stool.
Anabiosis - continued

NURSING CARE:

Absolute bed rest is necessary for a patient with an acute attack of amebiasis. Patient should be taught to wash his hands frequently, always after defecation and before touching food.
Fluid intake and urinary output should be carefully recorded.
Elevated temperature should be reported as this indicates a complication.

TREATMENT:

The aim of treatment is to eliminate the amebae from the intestinal tract and other parts of the body that have been invaded.

The drugs used here are:

- Corbo'sone for 10 days.
- Diodoquin for 20 days.
- Carbo'sone for 10 days.

These drugs are given in courses with periods of rest, and progress should be checked by stool examination. The treatment must be intensive and complete, and a relapse must be treated as fully as the first attack.

The patient is not considered cured until several stools have been checked and found free of ameba. Here, the usual number is three (3) stools free of ameba.
VIRAL HEPATITIS

Types:

There are essentially two types of viral hepatitis:

A. Infectious hepatitis (IH)
B. Serum hepatitis (SH)

A. INFECTIONOUS HEPATITIS

1. Incubation Period (the length of time between contact with the virus and the onset of illness): 15 to 60 days. The patient shows no signs or symptoms of illness during this period.

2. Prodromal Period (follows the incubation period and is the 2 to 14 days before the appearance of jaundice). During this phase, the patient develops marked loss of appetite, fatigue, malaise, lethargy, nausea, vomiting, diarrhea, distaste for cigarettes, fever between 100 and 104 degrees, cough, symptoms of URI, sensitivity of eyes to sunlight. In the last one to four days before the onset of jaundice, the urine becomes dark and the stool often becomes lighter in color. At this time, the Smith-Icto test for bilirubin in the urine will probably be positive.

3. Icteric Phase: (period during which jaundice is present). Duration is usually 6 to 8 weeks. G.I. symptoms usually decrease early and fever drops during the first week usually. Weight loss of 5-10 lbs. is common. The liver is usually enlarged and tender during this period and 26% of patients will have posterior cervical lymphadenopathy and an enlarged spleen. The hepatitis virus is present in the stools in all patients during this entire period but disappears as jaundice goes away. (Hepatitis virus is present in the stools of patients during the incubation period and the prodromal phase also).

4. Convalescent Phase: After the disappearance of jaundice, the patient usually exhibits residual lethargy, easy fatigability, enlargement and tenderness of the liver and abnormal liver function tests for an additional two to six week period. (Certain liver tests may be abnormal for a year or more).

5. Mortality: 0.1% to 0.4% of the patients with IH will die of the disease. Mortality rate is much higher for SH. Rate is highest among older patients and children and young adults seldom suffer complications or sequelae.

6. Prevention

a. Good hygiene: the only route of transmission thus far discovered is the anal-oral route, wherein the virus from the contaminated feces reaches the mouth of an uninfected person in some manner. The virus has never been found in urine or nasal discharges, etc. of patients with hepatitis. Wash hands frequently, dispose of fecal-soiled linens, avoid use of same dishes and silverware, etc.
b. Avoid close contact with patients. Because the virus is present in feces for as long as two weeks before the onset of jaundice and usually before the diagnosis of hepatitis is suspected, the benefit of isolation or quarantine measures is limited. Much spreading of the disease may be done by patients who are infected but do not show signs of being ill. All suspected cases should be isolated as completely as possible.

c. Gamma globulin: Most authorities agree that gamma globulin, if given early in the incubation period, will greatly lessen the severity of III. Gamma globulin will not prevent hepatitis. If one is going to develop III, he will do so even if he has received gamma globulin. He will also develop probable life-long immunity. Gamma globulin should be given to intimate contacts, pregnant women and elderly or debilitated patients who may have been exposed. The effect of gamma globulin lasts for approximately 2 months.

7. Treatment: a. Symptomatic only. No vaccine or antibiotic is effective.
   b. Bedrest: Once the diagnosis is made, the patient should be at bedrest during the entire icteric (jaundiced) phase.
   c. Diet: A regular diet which excludes cooked or fried fats is sufficient. Cooked or fried fats are excluded only because they tend to irritate the gastrointestinal tract and increase the severity of G.I. symptoms.
   d. Vitamins: Not necessary although given by many physicians.
   e. Steroids (Cortisone, etc.): given in severe, acute, fulminating cases only. Patients receiving steroids should be hospitalized.

B. SERUM HEPATITIS

1. Incubation period: 60 to 180 days.

2. Other phases: All are similar to those of III.

3. Transmission: Contaminated blood, plasma, needles, syringes, etc. I.M., I.V., S.Q. administration. Especially prevalent in drug users and addicts where the same needle and syringe may be used by many different persons without sterilization.

4. Mortality: 10-12% of patients with SH will die.

5. Prevention: Use of disposable needles, syringes, IV tubing, etc. Not administering whole blood or plasma unnecessarily. (The giving of one pint only is hardly ever indicated).

6. Treatment: The same as III
PEDICULOSIS
(Lice)

Pediculosis Capitus: Head lice.

Description: slender gray oval shaped body with spear shaped head.
24mm long.

Site of greatest involvement:
Scalp back of head - behind ears.

Symptoms:
1. Itching
2. May have secondary infections due to scratching.
3. Inflamed lymph glands.
4. May be facial impetigo and conjunctivitis.
5. Observe for appearance of minute white oval nits (eggs) which
are found firmly attached to the hair shafts. (Locks like
dandruff).

Transmission:
Personal contact, common wearing apparel, (hats) bed linens, combs,
brushes.

Treatment:
Notify cottage doctor to obtain order for treatment. Make out
Pharmacy requisition for topicide or other approved pediculosis
preparation ordered by physician.

1. Shampoo the hair.
2. When hair is completely dry put on disposable gloves and
anoint the scalp with pediculicide ordered with gauze sponge.
3. Comb the hair to work the solution through the hair.
4. Do not get solution into the eyes. Ammoniated mercury oint-
ment (Ophthalmic) may be used if prescribed by physician for
treatment of eyes.
5. Leave pediculicide solution on the head for length of time
directed.
6. May repeat procedure in 2-3 weeks if necessary.
PEDICULOSIS
( Lice )

Treatment: cont'd

7. Comb hair with fine tooth comb to remove nits.
8. To remain in cottage until pediculosis capitus (head lice) are removed.
9. Please return unused pediculicide solution to the pharmacy.
10. Keep patients undergoing treatment in one area.

KEY POINT: Pediculosis Capitis

1. Never shave an area without specific doctors orders.
2. It is important to check all patients on admission to the cottage or when returning from vacation or overnight visit.
3. Nits and lice must be removed manually with tweezers or hemostat from eyebrows and eyelashes.
4. Use caution so you will not get pediculicide solution in the eyes. Ammoniated mercury ointment (Ophthalmic) may be used if prescribed by physician for treatment of eyes.
5. Rinse combs and brushes well then soak in thermometer solution for a minimum of twenty (20) minutes.
6. Scour tub with scouring powder and rinse tub.
7. Care of linen and clothing:
   a. Please sort linen carefully. Do not shake linen. Nits and lice may shake off dirty linen into your clothing or body.
   b. Place colored clothes into one laundry bag (overalls, dress, shirts, etc.) and white linens into a separate bag. (Undercothes, sheets, etc.)
   c. Tie the top of the laundry bag.
   d. Fill out a shipping tag for each laundry bag with cottage name and ISOLATION.
   e. Attach the shipping tag to the laundry bags with 2 safety pins.
   f. Please notify the laundry that you are sending special tagged laundry.

Mattresses and pillows:

1. Cleanse with disinfectant solution.

Pillows:

1. Exchange contaminated pillow for new pillow through contacting Mrs. Ehrmann, Ext. 207.
Care, Treatment and Proper Handling of the Aggressive Resident.

Module IV - E
(Pre/Post Test)

Care and Treatment of the Aggressive Resident.

1. ______ copies of incident forms are completed for any injury or incident involving a resident or employee.
   A. Two
   B. Three
   C. One

2. The purpose of restraining and/or holding a resident is to manage the resident's behavior without:
   A. _____ Hurting yourself.
   B. _____ Hurting other residents.
   C. _____ Causing harm to the resident and/or yourself and others.
   D. _____ Hurting the resident's pride.

3. Restraint of a patient should only be:
   A. _____ Used by nurses.
   B. _____ Used as a last resort
   C. _____ Used by Supervisors
   D. _____ Used by a medical personnel

4. Name the three types of restraining holds used when one attendant is present!
   A. _______________________________
   B. _______________________________
   C. _______________________________

5. When a resident is assaultive and has a weapon (knife, fork, club, chair, etc.) an attendant: (Circle correct response)
   A. Does/Doesnot, attempt to get a weapon away from a resident.
   B. Does/Doesnot, get the assistance of another aide and try and cover the weapon with a towel, blanket or sheet.
   C. Does/Doesnot, in an extreme emergency with a very dangerous weapon, covers
the resident with a blanket, sheet, etc.

D. Does/Does not, try and handle the situation himself/herself.

6. If a resident has a front choke hold on you (check all correct responses):
   A. ____ Attempt to wrestle your way out of the hold.
   B. ____ Seek the assistance of another resident.
   C. ____ Grasp the resident's arm just below the elbow. Lift the resident's arms up and push his/her arms away from you.
   D. ____ Clasp your hands between yourself and the resident - underneath his/her arms. Bring your clasped hands up suddenly between his/her arms. Follow through until your hands are above your head.

7. List the three steps necessary in order to free yourself from a resident who has you in a back choke hold.
   A. _______________________________________________.
   B. _______________________________________________.
   C. _______________________________________________.

8. Describe how you would make a resident release his/her grip on an object.

   ____________________________________________________

   ____________________________________________________

   ____________________________________________________

   ____________________________________________________

9. What are the procedures used to release yourself from a resident who has a hold of both your wrists:
   A. _______________________________________________
   B. _______________________________________________
   C. _______________________________________________

10. What are the procedures used in freeing yourself from a resident who is pulling your hair (from the front):
    A. _______________________________________________
    B. _______________________________________________
11. What are the procedures used in freeing yourself from a resident who is pulling your hair (from the rear):
   A. ________________________________
   B. ________________________________________________

12. An aide should check all residents in restraints:
   A. Every 30 minutes
   B. Every hour
   C. Every 2 hours

13. A resident should have his restraints loosened _________________ for ambulation toileting, and fluids.
   A. ____ every two hours
   B. ____ once during each shift
   C. ____ every 30 minutes
   D. ____ when aide has time

14. How often should orders for restraints be reviewed and renewed?
   A. ____ bi-annual
   B. ____ monthly
   C. ____ every week
   D. ____ not necessary to renew

15. When lifting residents or other heavy objects the attendant should?
   A. ____ place feet close together and lift with back muscles
   B. ____ place feet close together and bend the knees
   C. ____ place feet slightly apart and lift with back
   D. ____ place feet slightly apart with knees bent and lift using leg muscles instead of the back.
16. The first step to take with a resident who is threatening others (or who may have already hurt others) is to:
   A. _____ Try and quiet the resident by talking to him/her calmly.
   B. _____ Place him/her immediately in restraint without finding out the cause of the incident.
   C. _____ Allow the resident to attack you - so that you can protect others.
   D. _____ Beat the resident up.

17. The second step to take with an assaultive resident (providing step 1 does not succeed) is to:
   A. _____ throw a blanket over the resident and tie him up.
   B. _____ shout at the resident.
   C. _____ gather help, and safely restrain the resident(s).
   D. _____ beat the resident up.

18. The key to "calming down" an aggressive (assaultive resident) is:
   A. _____ your fighting ability
   B. _____ remaining calm and being patient and understanding
   C. _____ your knowledge of choking and strangleholds
   D. _____ none of the above

19. The following restraining holds are illegal and are punishable under law:
   A. _____ arm holds.
   B. _____ elbow-wrist holds.
   C. _____ choking holds and strangleholds.
   D. _____ none of the above.

20. It is important to remember that restraints that are legal still should only be used to protect:
   A. _____ The medical staff.
   B. _____ The nursing staff.
   C. _____ The supervisory staff
   D. _____ Yourself, fellow aides, and other residents from injury.
21. Any restraint used should never:
   A. ___ Injure the resident.
   B. ___ Be used except in self-defense.
   C. ___ Be applied because an aide is mad at a particular resident.
   D. ___ All of the above.

22. List at least five suggestions for handling an aggressive resident:
   A. _______________________________________________________________
   B. _______________________________________________________________
   C. _______________________________________________________________
   D. _______________________________________________________________
   E. _______________________________________________________________

23. An acting out resident means a resident who tries to initiate the aide.
   A. ___ True
   B. ___ False

24. When a resident acts out this means that the aide has failed on his/her job.
   A. ___ True
   B. ___ False

25. To ask for help from other employees or supervisors when you are confronted with a violent resident is not an acceptable procedure.
   A. ___ True
   B. ___ False

26. When a resident becomes violent to himself, the first thing to do is:
   A. ___ Restrain him
   B. ___ Ignore him
   C. ___ To ask him, talk with him
   D. ___ Beat him up

27. The reasons for self-abusive behavior are the same for all residents.
   A. ___ True
   B. ___ False
28. Self-abusive behavior must be communicated to the supervisor only when:
A. The resident actually injures himself.
B. The resident makes you angry and upset.
C. Controlling aggressive behavior is part of his habilitation plan.
D. At all times.

29. Inappropriate resident behavior such as breaking windows, throwing furniture, and other violent acts of property should first be handled by:
A. Yelling loud enough at the resident to divert his attention so that others can rush in to secure the resident’s arms and legs.
B. Trying to talk to the resident quietly and then sternly if necessary.
C. Grouping together as many employees as possible to show your strength.
D. Securing the resident in a manner that he/she can not move.

30. When restraining the resident certain techniques should be used. You should:
A. refer to your manual on which hold to use.
B. have already been trained on how to handle the situation and employ the proper techniques.
C. do what you must to control the violent behavior, even if it means hurting the resident.
D. do nothing, the resident behavior will end before long.

31. True or False:
Keeping a calm cool head will get the job done without injury to staff or resident when proper procedures are followed.

32. If suicide is attempted you should:
A. give immediate first aid and then call for a physician.
B. call for a physician
C. give first aid
D. call for a physician and then give first aid

33. True or False:
A. the staff psychologists should be notified to find out why a resident attempts suicide.
B. ______ It is imperative that residents know that suicide will not be tolerated by anyone.

C. ______ A suicide victim should be made to feel ashamed.
Manual restraint consists of holding an individual for the purpose of restricting movements, to move an individual, or to permit you to walk a resistive person in a desired direction.

All personnel should be aware of the proper methods of holding a resident without resorting to such dangerous practices as choke holds, suffocation tricks, or blows of any kind. Willful injury to patients is forbidden and is subject to disciplinary action, (Executive Order G-3).

Points to remember:
1. Know what to do and how to do it. Practice the prescribed holds with your co-workers in order to become adept at them.
2. When more than one person is helping, each should know what each is to do.
3. Act quickly and surely.
4. Remove your glasses and watch and leave where they won't get broken—if you have time.
5. Remember the purpose of these holds and releases is to manage the patient's behavior WITHOUT causing harm to the resident or yourself.
6. Restraint of a patient should be used only as a last resort.

There are three general types of holds:
1. Used when only one person is present.
2. Used when two or more persons are present.
3. Used to release the patient's hold on you.

**Type 1** — used only when one person is present

A. **Arm hold** — used to protect you when walking a resident who may be impulsive but who may become upset by a stronger hold.
   1. Grasp the resident's left arm just above the elbow with your right hand.
   2. If the resident tries to strike you with his/her right hand, push his/her left arm up toward his/her face.
   3. You may pull the resident toward you so that his back is toward you.

B. **Elbow-Wrist Hold** — used to permit your walking a midly resistive resident in a desired direction.
   1. Approach the resident from the left side.
   2. Grasp the resident's left wrist with your left hand and his/her left elbow with your right hand.
3. Raise his/her elbow with your right hand and lower his/her wrist, forming a right angle at the bend of the resident's elbow.

4. You may apply pressure by drawing back on the wrist and pushing forward on the elbow.

5. You may hold the resident's arm close to his/her back and move him/her in the desired direction.

6. This hold MAY NOT be effective on a large and active resident.

**Type II** - used when two or more persons are present.

**A. Two Persons** - used when necessary to walk a resident to a destination.

1. Approach the resident, one person from each side.

2. Slip the arm nearest the resident UNDER the resident's arm above the elbow.

3. At the same time grasp the resident's wrist with your other hand.

4. With the hand of the arm which is under the resident's arm, grasp the wrist of your other arm to secure your hold.

**B. Four Persons** - used when necessary to carry a resident to a destination.

1. Decide what each person is to do.

2. Approach the resident, two persons from each side.

3. The first two persons secure the arms as in "A" preceding.

4. The other two persons secure a leg hold similar to the arm hold but grasp each other's wrists instead of his arm.
   a. Place arm nearest resident under the resident's leg and grasp his/her ankle with your other hand.
   b. Bend the resident's knees and raise his/her feet off the floor ------- both persons coming as close together as possible.
   c. With the hand of the arm under the resident's leg, grasp the wrist of the other person who is holding the resident's ankle.
   d. Hold the resident's leg with knees bend and as close together as possible to keep the resident from kicking loose.
   e. Carry the resident to the desired destination.

**C. When the resident is assaultive and has a weapon, (knife, fork, club, chair etc).**

1. Do not attempt to get a weapon away from a resident when you are alone

2. With the help of at least one other person try to cover the weapon with a towel, blanket or sheet.
3. In an extreme emergency with a very dangerous weapon, it may be necessary to throw a sheet or blanket completely over the resident.

4. If the weapon is extremely dangerous, have plenty of help and try to back the resident into a corner, protecting yourself with a mattress held in front of you.

**Type III** - used to release the resident's hold on you.

A. **Choke release** - to release yourself from a resident who is choking you from the front, with arms outstretched and hands at your throat.

   **Method 1.**
   a. Clasp your hands between yourself and resident, underneath his/her arms.
   b. Bring your clasped hands up suddenly between his arms.
   c. Be sure to follow through until your hands are well above your head.

   **Method 2.**
   a. Grasp the resident's arm just below the elbow.
   b. Lift the resident's arms up and push his/her arms away from you.

B. **Neck Releases** - used to release the hold of a resident who has his arms around your neck from the rear and is choking you.

   1. Turn your neck to the side to relieve the pressure on your larynx.
   2. Grasp the wrists of the resident and push outward as you raise the resident off the floor on your back.
   3. Raise and lower your body rapidly to loosen his hold and pivot quickly.

C. **Hand Release** - to make a resident release his/her grip on an object.

   1. Bend your forefinger to extend the knuckle.
   2. Press the extended knuckle against the nerve found in the groove on the back of the hand between the forefinger and middle finger.
   3. Apply just enough pressure until the resident releases his grip.

D. **Wrist Release** - used to release yourself from a resident who holds both of your wrists with his hands.

   1. Make your fists as hard as possible.
   2. Turn your wrists inward and press down.
   3. With a sudden snapping motion, draw your fists in, up and then outward against the resident's thumb.
E. **Hair Release** - used to release yourself when a resident is pulling your hair from the front with his/her right hand.

1. Clasp the resident's right wrist with your left hand.
2. Step forward and to the left of the resident with your left foot.
3. Slip your right arm under and around the resident's right arm above the elbow and grasp the patient's right wrist.
4. Bend your body forward and force the resident's arm down.

F. **Hair Release** - used when a resident grasps your hair from the rear.

1. Clasp both of your hands over the resident's hand and wrist.
2. Turn quickly to the right, bending from the waist, and getting your head as close to the floor as possible - face the resident, push her hand and wrist to your left at the same time.
CRISIS INTERVENTION

In the event of a resident becoming violent to himself; to others; to property.

I. To himself

Behavior:
Biting himself, banging head against the wall, etc...

a. Try to talk to the resident softly, and if necessary, sternly. Try to make him feel secure and to stop on his own. If this fails then:

b. Gather several staff members (three to five) and subdue the resident. It would be best to have one or two people get behind him and restrain his legs (about the knee) from behind. Hands should then be restrained with a soft cloth and the cottage doctor notified. His approval in writing must be obtained. In the event of head banging, protective head gear should additionally be employed.

c. Following restraint, efforts should be made by the staff (psychologist if available) to calmly talk to the resident and soothe him.

d. Following this strategy, staff members should try to ascertain the reasons for the violent action in order to avoid the behavior in the future. Staff members should talk to the resident in question as well as others present at the time of the violent behavior.

II. Violence to Others

Behavior:
Fighting with other residents or staff members.

a. Try to quiet the resident(s) first by talking calmly, and if necessary, sternly. If this works, try to find out the cause of the violence and help the resident(s) understand what happened and why. If this fails then:

b. Enough staff should be gathered to safely restrain the residents. If more than one is involved more help may be needed in the form of aides from adjoining cottages.

c. Staff should restrain the resident from behind, preferably about the knees. At this time the remaining staff should tie the hands with a soft cloth and notify the cottage physician.

d. Procedures for calming the resident through talking, should be taken, as well as trying to ascertain the reasons for the violence in the first place. Discussions with the resident and those present during the violence will be of great aid. The key here is patience and understanding.
III. Violence to Property

Behavior:

Breaking of windows, throughing furniture

a. Try to talk to the resident first quietly and then if necessary, sternly. It is necessary to calm the resident and make him/her feel secure.

b. If it becomes necessary, use the aforementioned techniques for restraining the resident. Always have enough staff on hand to do the job safely, both for you and the resident. Keeping a calm, cool head will get the job done without injury to staff or resident.

Suicide

Suicide in the institution, if not rare, is non-existent. If it occurs however, immediate first aid should be rendered and the physician called for. Staff psychologists should be notified to help ascertain the reasons for the attempt. It is imperative that these individuals be made to feel secure. Repeated attempts may be met with restraint and/or close observation until the psychological staff has time to complete therapy.
Hints for Your Own Protection

1. Be certain not to go into an isolated area or hallway unless accompanied by another employee or informing another employee where you are going.

2. Always approach patients from the side; never stand directly in front or behind a resident.

3. When a resident seems upset, keep yourself calm. Keep a calm friendly, and sincere manner. Do not become upset or angry - you will further excite the resident.

4. When approaching an excited resident, make certain that you have employee help at hand in case you should require assistance.

5. Never enter a seclusion room alone. Leave the room facing the patient.

6. Never attempt to restrain or seclude a patient without help.

7. Report immediately all incidents-accidents or injuries. Use the Incident Blank Form.

8. Never sign any papers for patients or visitors.

9. In answering visitors' questions, stay within your bounds. Technical questions or problems should be referred to the proper authority-supervisor, social worker or the doctor. Be pleasant and sincere at all times.

10. You keys are to remain in your pocket. They should not be loaned to anyone or layed down. If you should loose your keys, report this immediately to the Security Department.

11. Always lock a door that you unlocked, and check to see that it is locked. If you come to a door that should be locked and is not, you lock it and then check with the ward personnel in that area.

12. Before unlocking a door, check to see that no patients are loitering near-ready to try to escape. If the patient will not be directed back to the ward area summon another employee before unlocking the door. This way you will have assistance should the patient attempt to escape.

13. Do not permit residents to loiter in the ward office, shower room, utility room or secluded areas of the ward.

14. Confused residents, residents in bed or in seclusion are to be supervised while smoking. They are not to be unattended. Residents are not to carry matches or lighters. All patients and employees are expected to follow smoking rules and regulations.
THINGS WHICH YOU CAN DO TO REDUCE THE NEED FOR BEHAVIORAL RESTRAINT

1. Know your patient's behavior patterns. An increased talkativeness, flushed face, restless pacing the floor, careless donning of clothing are just a few warning signs of approaching upset behavior. Occasionally a patient will have enough insight, or understanding, of his behavior that he will ask to be put in a room away from the other patients.

2. Give the patient something to do at which he can use his pent-up energy; such as: Calisthenics, games which can be played out-of-doors, ward work such as bedmaking, putting away linens, sweeping floors, dusting; tearing rags for rug making, magazines (which have been read) for tearing and card games or checkers will sometimes interest the patient to the extent that he will slow down his activity in order to concentrate on the game.

3. Soft, nonstimulating music (no rock-n-roll) has a calming effect on some residents. (Use of a record player permits specific selection of music desired).

4. A well-planned routine of occupational and reactional therapy can provide means for patients to work off excess energy as well as feelings of anger and hostility. A punching bag for instance, is much better for a resident to hit than for him to hit another resident.

5. Ideally, an excited, over-active, upset resident should have personalized attention from a psychiatric technician until he gets over his disturbed period. Unfortunately, too many hospitals do not have adequate staffing, so restraint or seclusion is substituted.

6. The use of hydrotherapy, in the form of cold wet sheet packs or continuous tub baths, is sometimes ordered for the treatment of over-active resident. The psychiatric technician does not perform these procedures unless they have been given specific instructions in their correct application by a licensed therapist, the doctor or a registered nurse.

SUGGESTIONS FOR HOLDING OR HANDLING RESISTIVE OR DISTURBED RESIDENTS

There may be times when it is necessary to temporarily restrain and control a resident's movements. Examples of such instances are: the necessity for carrying out a nursing care procedure, the need for a physical examination of a specific area of the body, or disturbed behavior. You should then be aware of the following:

1. Type of restraint must not injure the patient.
2. At least two persons should carry out such restraints.
* 3. Plan your maneuvers in advance.
* 4. At the sign of approaching trouble remove your own glasses if you wear them, watch, fountain pen or anything of value.
* 5. If the resident is wearing shoes with "hard" soles, remove the shoes to prevent injury to others.
6. If a female resident is mildly excited it may be sufficient to walk beside her, placing an arm around her waist and grasping the wrist of the forearm with your hand; with your other hand grasp the wrist of the resident's other arm drawn toward the front of the body. The other person should walk on the other side of the resident.
7. Do not touch a male resident, the employees should walk one on each side of the resident. If necessary, take hold of an arm, flex the arm at the elbow, and place your arm between the resident's arm and body and clasp the wrist. Walk with the resident, all walking forward. If the resident is hard to manage use the same method as above except that the resident's arms are drawn to the back. Have the resident walk backward, the nursing employees walk forward.

8. All workers should know where the resident is being taken, if he is being moved, so that they move in the same direction.

9. To prevent biting, scratching, and hitting, keep behind the resident or at the side; if you take hold of the resident's arm, grasp the wrist.

10. Never take hold of an excited resident by the hand and pull forward; the resident immediately pulls backward and has control of his maximum strength.

11. In applying pressure, as in holding a wrist, have some cloth between the resident's flesh and your hand; this reduces the possibility of bruising. Hold on to the resident but exert pressure only when necessary. Never exert pressure over the chest.

12. If the resident has a dangerous object such as a hammer or knife, place first attention on the article. If necessary throw something - a sheet, a blanket or a large garment--over the resident's face. Use a mattress as a shield. In extreme situations approach the resident from behind.
I. Prerequisites

a. This learning experience assumes that you have completed Modules I thru IV of the Mental Retardation Worker I Curriculum.

b. Comparable knowledge or experience.
II. Directions for the Learner
   a. You will first be tested on your current knowledge of communication. Upon completion of this "pre"-test, various learning experiences will be provided covering information concerning communications.

   b. Upon completion of the learning experiences on communications, you will again be tested, "post"-test, in order to determine your degree of comprehension.

   c. Proceed at your own rate of speed. There are no time limits on this learning exercise. Notify your supervisor upon completion of this module. She/he will then coordinate your final examination on the information you learn in this learning experience. You will then be notified of your results. If you successfully pass the final examination you will then proceed to Module 3. If you do not successfully pass the final examination, you will have to study this Module until you do.

   d. Good luck - enjoy your experience. Please proceed on to the "pre"-test examination and begin answering each question to the best of your ability.
III. Pre-test

1. Define communications ________________________________

2. Which of the following is not a skill in communication?
   a. the words we use
   b. the manner in which we express them
   c. talking in a monologue about ourselves
   d. the body movements we use when speaking

3. __________________________ is responsible for most of the problems involving interpersonal relationships.

4. Listed below are examples of ways in which we communicate. Check those which lead to improve communications.
   __ good taste
   __ common sense
   __ interrupt
   __ use "I", "ME", and "MY" frequently
   __ use "YOU" and "YOURS" frequently
   __ repeat yourself
   __ use mannerisms
   __ give others a chance to talk
   __ listen carefully
   __ be tactful
   __ laugh at others
   __ be kind
   __ make other people feel important
   __ think before speaking
   __ pass on confidential information
   __ say nothing
   __ pass on rumors
   __ understand others' point of view
   __ pass judgement
   __ know what you are disagreeing with
   __ ask for details
   __ argue
   __ use persuasion in a disagreement
   __ use name-calling in a disagreement
5. Why do we ask questions?
   
   a. to obtain specific information  
   b. to get suggestions and ideas  
   c. to find out the other person's opinion  
   d. to encourage a change in behavior  
   e. to emphasize a point  
   f. all of the above  

6. Listed below are examples of telephone communications. Check those which are appropriate for the Mental Retardation Worker on the Unit.
   
   a. let phone ring several times  
   b. give name, title, and unit when answering  
   c. politely do ask the caller his name  
   d. address caller by name  
   e. keep pad and pencil near phone at all times  
   f. deliver messages to proper party promptly  
   g. do not ask caller to repeat message, even if you are uncertain  
   h. be impersonal and formal  
   i. scream into the speaker  

7. True or False:
   
   a. listening is less important than speaking  
   b. high levels of noise can lead to hearing loss  
   c. the acoustics of a room, loud noises, poor ventilation, and uncomfortable temperatures are all barriers to listening  
   d. speaking very slowly and softly will help the listener hear you  
   e. the ability to concentrate requires mental effort  
   f. people are more interested in themselves than other people  
   g. people can listen at a faster rate than people talk  
   h. listening is a minor part of conversation  
   i. listening is the first step to persuasion  
   j. listen to the content, not the manner
8. The following are examples of rules which can apply to written communications. Check those which lead to improved written communications.

- know what you're going to say
- use big words
- a long report is a good report
- spell correctly and use good grammar
- avoid examples
- stick to the subject
- always express your opinion in a factual report
- keep your report interesting and formal
- keep your writing legible

9. The most important responsibility of the attendant is to develop ______________________ with the residents.

- a. good relationships
- b. discipline
- c. authority
- d. control

10. True or False

- each resident should be thought of as an individual
- personality types do not vary much among the retarded
- the M.R. Worker should supervise, direct and control the resident
- the M.R. Worker should guide and influence the residents
- always give large amounts of attention to those residents which are your favorites
- never show hostility or rejection
- accept the resident as he is
- behavior outbursts are the result of bad temper
- in order to work with the retarded, you have to be able to detach yourself from your work
- residents often show immature personality characteristics as a result of their disability
- M.R. Worker should give psychotherapy when needed
11. Which of the following are defense mechanisms?
   ___a. projection
   ___b. withdraw
   ___c. regression
   ___d. rationalization
   ___e. need for reassurance
   ___f. all of the above

12. Which of the following techniques can be used in guiding the resident?
   ___a. make sure the resident understands what you are saying
   ___b. avoid being abstract: use simple words
   ___c. be alert to emotional reactions of resident
   ___d. provide reasonable directions
   ___e. stick to one immediate problem
   ___f. avoid derogatory terms
   ___g. all of the above

13. Which of the following are appropriate statements to make to the parent or guardian of a resident? (check them)
   ___ "Joey is doing fine"
   ___ "He has learned to feed himself"
   ___ "Your daughter was unmanageable for days after her last home visit with you"
   ___ "Susie does bite herself when upset"
   ___ "Are your emotional problems being treated"
   ___ "I know all about you and your family"
   ___ "Your son drives me crazy"
   ___ "Edward enjoys his trips to the canteen with me"
   ___ "The psychology record says your son has a mental age of 3"

14. Write a statement about your responsibility for confidentiality of the resident's records. (2-3 sentences)

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
15. True or False:

- Confidentiality is violated if you discuss residents with your family and neighbors.
- Confidentiality of resident records is protected by law (S.B. 336).
- Confidentiality is violated if you discuss resident records with the resident's family.
- You may release information on request to any person without permission of the resident or guardian.
- If you accidentally deface or lose a unit record on a resident, it does not have to be reported.

16. Residents are permitted free and unsupervised use of which of the following:

- a. Telephone (calling and receiving)
- b. Opening their own mail and packages
- c. Sending or receiving mail without censorship
- d. All of the above
- e. None of the above
(A.) COMMUNICATIONS OVERVIEW
Read the following and move on to the Post-Test.

1. Communications Overview
2. Communications in Nursing (Kron)
3. Better Report Writing (Dynamic Supervision)
4. Understand the Mentally Retarded (Gareth D. Thorne)
5. Confidentiality (Standards for Residential Facilities for the Mentally Retarded, Joint Commission on Accreditation of Hospitals)
6. Statement on Confidentiality (Broadview Center Policy)
IV. Purpose of the Module
   a. The purpose of this module is to familiarize the Mental Retardation Worker I trainee with communication on the job.

V. Assumptions
   a. That the Mental Retardation Worker I trainee will learn through the learning experiences outlined in this module, the importance of communications on the job.

   b. That the Worker-Trainee has met the prerequisites as outlined on page 1.

   c. That the Worker-Trainee passing the Post-Test will proceed to the next module.

VI. Motivational Aspects
   a. It is important for the Worker-Trainee to understand and use the tools of communication in order to maintain the requirements of the job and satisfactory relationships with residents, peers, supervisors and parents.
VII. Terminal Objectives

1.0 - To understand the meaning and importance of communication on the job and successfully complete the post-test examinations at the 75% level of competency.

1.1 - To write an acceptable definition of communication.

1.2 - To select three (3) communication skills from a list.

1.3 - To identify the purpose of communication.

1.4 - To correctly select those methods that lead to effective oral communication.

1.5 - To identify why we ask questions.

1.6 - To correctly select the methods used for effective telephone conversations.

1.7 - To identify accurate statements about the art of listening.

1.8 - To correctly select those methods that lead to effective written communication.

1.9 - To identify information essential to understanding and guiding the resident.

1.0.0 - To select responses which are appropriate.

1.0.1 - To state the meaning of confidentiality and identify the various aspects covered.
1.0.2 - To identify the types of communication permitted for the residents.

VIII. Enabling Objectives

2.1 - To know the definition of communication.

2.2 - To know the skills of communication.

2.3 - To know the importance of communication

2.4 - To know how to speak effectively

2.5 - To know why we ask questions.

2.6 - To know how to use the telephone effectively on the unit.

2.7 - To know the role of listening in communications.

2.8 - To know how to write effectively.

2.9 - To know the basic principles for communications between the M.R. Worker and residents.

2.0.1 - To know appropriate ways to communicate with parent or guardian.

2.0.2 - To understand the meaning and importance of confidentiality.

2.0.3 - To recognize rights to communication for the residents.
XI. LISTED READINGS

TO MODULE V

1. Communications Overview
2. Communications in Nursing (Kron)
3. Better Report Writing (Dynamic Supervision)
4. Understand the Mentally Retarded (Gareth D. Thorne)
5. Confidentiality (Standards for Residential Facilities for the Mentally Retarded, Joint Commission on Accreditation of Hospitals)
6. Statement on Confidentiality (Broadview Center Policy)
X. POST-TEST

1. Define communications

2. Which of the following is not a skill in communication?
   a. the words we use
   b. the manner in which we express them
   c. talking in a monologue about ourselves
   d. the body movements we use when speaking

3. ___________________________ is responsible for most of our problems.

4. Listed below are examples of ways in which we communicate. Check those which lead to improved communications.
   a. good taste
   b. common sense
   c. interrupt
   d. use "I", "ME", and "MY" frequently
   e. use "YOU" and "YOURS" frequently
   f. repeat yourself
   g. use mannerisms
   h. give others a chance to talk
   i. listen carefully
   j. be tactful
   k. laugh at others
   l. be kind
   m. make other people feel important
   n. think before speaking
   o. pass on confidential information
   p. say nothing
   q. pass on rumors
   r. understand other's point of view
   s. pass judgement
   t. know what you are disagreeing with
   u. ask for details
   v. argue
   w. use persuasion in a disagreement
   x. use name-calling in a disagreement
5. Why do we ask questions?
   a. to obtain specific information
   b. to get suggestions and ideas
   c. to find out the other person's opinion
   d. to encourage a change in behavior
   e. to emphasize a point
   f. all of the above

6. Listed below are some examples of telephone communications. Check those which are appropriate for the Mental Retardation Worker on the Unit.
   - let phone ring several times
   - give name, title, and unit when answering
   - politely do not ask the caller his name
   - address caller by name
   - keep pad and pencil near phone at all times
   - deliver messages to proper party promptly
   - politely do not ask caller to repeat message, even if you are uncertain
   - be impersonal and formal
   - speak loudly into the speaker

7. True or False:
   - listening is less important than speaking
   - high levels of noise can lead to hearing lose
   - the acoustics of a room, loud noises, poor ventilation, and uncomfortable temperatures are all barriers to listening
   - speaking very slowly and softly will help the listener hear you
   - the ability to concentrate requires mental effort
   - people are more interested in themselves than other people
   - people can listen at a faster rate than people talk
   - listening is a minor part of conversation
   - listening is the first step to persuasion
   - listen to the content, not the manner
8. The following are examples of rules which can apply to written communications. Check those which lead to improved written communications.

- know what you're going to say
- use big words
- a long report is a good report
- spell correctly and use good grammar
- avoid examples
- stick to the subject
- always express your opinion in a factual report
- keep your report interesting and formal
- keep your writing legible

9. The most important responsibility of the attendant is to develop ___________________________ with the residents.

- a. good relationships
- b. discipline
- c. authority
- d. control

10. True or False:

- each resident should be thought of and worked with as an individual
- personality types do not vary much among the retarded
- the M.R. Worker should supervise, direct and control the resident
- the M.R. Worker should guide and influence the residents
- always give large amounts of attention to those residents which are your favorites
- never show hostility or rejection
- accept the resident as he is
- behavior outbursts are the result of bad temper
- in order to work with the retarded, you have to be able to detach yourself from your work
- residents often show immature personality characteristics as a result of their disability
- M.R. Worker should give psychotherapy when needed
11. Which of the following are defense mechanisms?
   ___a. projection
   ___b. withdraw
   ___c. regression
   ___d. rationalization
   ___e. need for reassurance
   ___f. all of the above

12. Which of the following techniques can be used in guiding the resident?
   ___a. make sure the resident understands what you are saying
   ___b. avoid being abstract: use simple words
   ___c. be alert to emotional reactions of resident
   ___d. provide reasonable directions
   ___e. stick to one immediate problem
   ___f. avoid derogatory terms
   ___g. all of the above

13. Which of the following are appropriate statements to make to the parent or guardian of a resident? (check them)
   ___ "Joey is doing fine"
   ___ "He has learned to feed himself"
   ___ "Your daughter was unmanageable for days after her last home visit with you"
   ___ "Susie does bite herself when upset"
   ___ "Are your emotional problems being treated"
   ___ "I know all about you and your family"
   ___ "Your son drives me crazy"
   ___ "Edward enjoys his trips to the canteen with me"
   ___ "The psychology record says your son has a mental age of 3"

14. Write a statement about your responsibility for confidentiality of the resident's records. (2-3 sentences)

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
15. True or False:

- Confidentiality is violated if you discuss residents with your family and neighbors
- Confidentiality of resident records is protected by law (S.B. 336)
- Confidentiality is violated if you discuss resident records with the resident's family
- You may release information on request to any person without permission of the resident or guardian.
- If you accidentally deface or lose a unit record on a resident, it does not have to be reported.

16. If properly trained, you are allowed to communicate the following information about residents to his relatives:

- a. none
- b. needs and program only
- c. information in the resident records only
- d. needs, program and information in the records

17. Residents are permitted free and unsupervised use of which of the following:

- a. telephone (calling and receiving)
- b. opening their own mail and packages
- c. sending or receiving mail without censorship
- d. all of the above
- e. none of the above
I. Prerequisites
   a. This learning experience assumes that you have successfully completed modules 1 through 5 of the Mental Retardation Worker I Training Package.

   b. Have comparable experience or knowledge.
II. Directions for the Learner

a. You will first be tested on your current knowledge of Unit Life Procedures. Upon completion of the "Pre"-Test, various learning experiences will be provided, covering information concerning Unit Life Procedures.

b. Upon completion of the learning experiences on Unit Life Procedures, you will again be tested, "Post"-Test, in order to determine your degree of comprehension.

c. Proceed at your own rate of speed. There are no time limits on this learning module. Notify your supervisor upon completion of the module, and he/she will then coordinate your final examination. You will be notified of the final results in a short period of time.

d. Good luck - enjoy your experience. Please proceed on to the "Pre"-Test examination and begin answering each question to the best of your ability.
III. Pre-Test

I. The following is a list of the rights of the institutionalized retarded citizen. Following each right is a situation which calls on you as the mental retardation worker to preserve and protect these legal rights. Respond by checking the choice(s) which is/are the most correct way(s) to handle the situation. Many times there is more than one choice.

A. The right of freedom of choice within the individual's capacity to make decision.

1. Raymond, who works daily in the institution sheltered workshop refuses to take a shower. On this day his lack of hygiene is especially notable. In this situation you should:
   ___a. Physically force Raymond to take a shower.
   ___b. Tell Raymond he cannot go to the workshop unless he takes a shower.
   ___c. Tell Raymond he cannot have his breakfast until he takes a shower.
   ___d. Tell Raymond his smell is most offensive to you and that you prefer not to be around him until he takes a shower.
   ___e. Tell the workshop staff the Raymond "smells like a horse" and that they should straighten him out.

B. The right to live in the least restrictive, individually appropriate environment.

2. Alice, a woman in her forties, lives on a unit with severely and profoundly retarded residents. In working with Alice you find that although she is blind and has a humped back (scoliosis), she
is a very social person who has many normal interests. One of these interests is knitting which she learned as a young girl. However, Alice is not allowed to knit as the other residents may take her knitting needles and injure themselves. You should:

_a._ Follow the rules and continue as you have.

_b._ Recommend to the supervisor that Alice be transferred.

_c._ Refer Alice's problem to the unit social worker or to her habilitation plan manager.

_d._ Teach Alice to crochet or macrame or other activity which does not require the use of pointed needles,

_e._ Tie the knitting needles to Alice's arm so that other residents may not steal them.

C. The right of the institutionalized citizen to express themselves verbally, through phone conversations (the resident must pay for toll calls) or through written communication.

3. Cindy, a teenage girl on your unit, takes a great delight from calling you "bubble-ass". For obvious reasons this habit annoys you. You should:

_a._ Totally ignore Cindy when she calls you "bubble-ass".

_b._ Take Cindy aside and tell her that there are many unattractive things about her but since you're a good person you won't bring them up.

_c._ Suggest to the supervisor that Cindy's privileges be suspended until she treats you with proper respect.

_d._ Take Cindy aside and administer corporeal punishment.

_e._ Go on a diet.
D. The right of the resident or guardian to refuse to participate in any phase of the habilitation services.

4. Carl, a man in his sixties, refuses to go bowling with the group the activity therapist takes each Friday afternoon. His only excuse is, "I hate bowling."
   ___a. Tell Carl he cannot watch T.V. during the time the rest of the residents are bowling.
   ___b. Talk to Carl about his habilitation plan and tell him that bowling is an important activity which he must do in order to get well.
   ___c. Respect Carl's wishes.
   ___d. Tell Carl that he doesn't have to go bowling but that it would make everyone feel better if he did.
   ___e. Talk to the activity therapist about another activity for Carl.

E. The right to protection against exploitation, demeaning treatment, or abuse.

5. Ignace, a Mental Retardation Worker II, has worked on the unit for a number of years. He has a nickname for each of the residents. Some nicknames are affectionate, "Cupey", "Smiley", and "Sonny". Some are not affectionate, "Burrhead", "Dopey", "Hurd", and "Gimp". The residents don't seem to mind. In fact many call themselves by these names. When you object to the supervisor that you find these names demeaning, he replies, "Oh, Iggy has worked here a long time. The residents love him". You should:
   ___a. Report Ignace to the unit director, going over the supervisor's head.
   ___b. Make your objection in writing to the supervisor.
c. Continue calling the residents by their first and last names.

d. Forget it.
e. Talk to Iggy yourself and tell him you find his nicknames demeaning.

F. The right to participate in a comprehensive set of habilitative programs appropriate to his or her level of intellectual functioning.

6. Lorretta is a young woman on your unit. She is confined to her wheelchair. She has many jerky movements. You learn that she has a condition known as Cerebral Palsy. Although Lorretta cannot speak, you have learned to understand Lorretta through her gestures and facial expressions. You have also learned through your contact with her that Lorretta is a sensitive person who has a good sense of humor and that she can follow your conversation with her. You also feel that she may benefit from physical therapy.

Lorretta has been placed on a unit with profoundly retarded, non-ambulatory residents. She is fed all her meals and diapered. She spends most of her time watching T.V. Twice a week an activity therapist comes to the ward and plays a piano for the residents. An occupational therapist checks her chair once a month and occasionally adds padding to it. She is weighed once a month and sees the doctor irregularly. When you ask the supervisor if you can take Lorretta outside for a walk, she tells you, "No, that's not a good idea. The other patients might want to go out, too".

You feel Lorretta could be toilet-trained, taught to feed herself, could benefit from physical therapy, and would probably enjoy movies, walks, and attending social functions. When you talk to the unit social worker about this, he tells you, "Lorretta's
profoundly retarded, and she's on a "non-am" unit. We have a set habilitation plan for those people. It doesn't include those things". You should first (only one answer here):

___a. Ask your supervisor if you could be included in the next review of Lorretta's habilitation plan.

___b. Start reading up on Cerebral Palsy.

___c. Ask the occupational therapist if there are special utensils that can be used to help Lorretta feed herself.

___d. Ask Lorretta to tell you when she has to go to the bathroom.

___e. Introduce Lorretta to the unit social worker, her habilitation plan case manager, or to your supervisor and explain Lorretta's gestures and facial expressions.
During the following exercise the following terms will be used.

1. "least restrictive setting" - This means an environment which is as near to that which "normal" non-institutionalized citizens enjoy as is possible.

2. "individual habilitation plan" - This means the care and treatment plan known as the habilitation plan which had been designated by the hospital interdisciplinary team for each resident. Each individual habilitation plan has a "case manager" who may be a member of the professional staff (psychologist, teacher, social worker, etc.) or a member of the direct staff (supervisor, M.R. Worker II, nurse, etc.). It is the case manager's duty to see that the individual habilitation plan is carried out.

3. "active treatment" - This means an aggressive, organized effort to deliver and provide these services and treatments outlined in the individual habilitation plan to meet specific behavioral objectives.
IV. Read before responding to the True/False Questions.

The rights of the institutionalized mentally retarded citizen are the same as any other citizen and include, but are not limited to:

1. The right to freedom of choice within the individual's capacity to make decision.

2. The right to the least restrictive individually appropriate environment.

3. The right of the resident or guardian to refuse to take part in any phase of habilitative services.

4. The right of protection from exploitation, demeaning treatment or abuse.

5. The right when taking part in research projects to be safeguarded from violations of human dignity and to be protected from physical and psychological abuse.

6. The right to participate in a comprehensive set of habilitative programs appropriate to his or her level of functioning.

7. The right to be free from physical restraint such as isolation except in emergency situations when the resident may harm himself or others.

8. The right to receive prompt and adequate medical treatment for any physical ailment, injury or discomfort.

9. The opportunity for religious worship.

10. All residents, including non-ambulatory residents, shall be dressed daily including shoes unless contraindicated in written medical orders.

11. The right to adequate storage space for his or her belongings.

Considering these rights of the retarded citizen answer the following questions.

True or False (use T or F):

1. Most retarded can't understand the language so they need not be told of their habilitation plans.
2. There is no need to explain the purpose of activities and training programs to the retarded.

3. The retarded have a right to worship God.

4. The physical welfare of the resident must be safeguarded during research projects.

5. If a retarded person wets and soils himself, it is proper to isolate that person in a locked room.

6. It is appropriate for several retarded people to share a closet or dresser.

7. Non-ambulatory residents who are kept in bed most of the day need not be fully dressed.

8. Since retarded citizens often cannot describe their physical ailments it is important for the mental retardation worker to be especially alert to any change in their appearance or manifestation of pain.

9. When one retarded resident strikes another resident he must automatically be placed in seclusion or isolation.

10. A resident can refuse to go to school or to attend an activity.

11. A resident can refuse to attend a religious service.

12. Mildly to moderate retarded residents can be housed in a living area with profoundly retarded residents.

13. Residents or guardians can refuse to take part in research projects.

14. If a retarded resident receives no treatment or habilitation the hospital superintendent and other responsible parties can be found to be in violation of the law. (Often referred to as S.B. 336)

15. Considering the rights of the mentally retarded it is obvious that legally the retarded are considered to not be able to make decisions concerning their welfare.

16. Retarded citizens do have the same rights as any other citizen plus...
several more if they are institutionalized.

17. It is appropriate to call residents by any nickname if that resident likes the nickname.

18. Since institutionalized retarded residents are "ward of the state" they have the right to receive only those services that the state can afford to provide.

19. The superintendent of a state institution can decide on his own what is the best possible treatment for the resident of that institution.

20. A unit supervisor can decide on his or her own initiative what is the best possible treatment for the resident of that unit.

21. A mental retardation worker cannot decide on his or her own initiative what the best possible treatment is for the resident in his charge.

22. Mentally retarded residents can never be responsible for their own behavior and actions.

23. The mental retardation worker must follow orders from his immediate supervisor even if those orders are in violation of the resident's rights.

24. Mentally retarded citizens really are not citizens and really should not have any rights.

25. You are walking across the street. You are struck by an automobile. You suffer a massive cerebral hemorrhage. You suffer significant brain damage. You are totally incapacitated. You are placed in an institution. You are housed on a non-ambulatory unit, with severely and profoundly retarded residents. You should have no legal rights.

26. As a mental retardation worker you will often have to protect the rights of the mentally retarded.

27. All residents regardless of age, interests or disability should be sent to bed at the same hour.
28. All residents should be gotten out of bed each morning at the same hour.
29. Mentally retarded citizens should be allowed to take reasonable risks.
30. The mentally retarded should be protected from failure.
31. The mentally retarded should be encouraged to form relationships with the opposite sex.
32. The mentally retarded should be allowed to be sexually deviant.
33. The mentally retarded should always be humored and allowed to get their way.
34. You should never tell a retarded that you disapprove of his or her behavior.
35. A mental retardation worker should never strike a retarded resident.
36. If a mental retardation worker does strike a mentally retarded resident, he or his co-workers should immediately report the incident to his immediate supervisor.
37. Mental retardation workers should never discipline a resident.
38. It is often necessary to repeat a request to a mentally retarded resident as the resident often has difficulty understanding requests or instructions.
39. It is appropriate to discuss a resident's behavior with your supervisor or co-worker while the resident is within hearing range.
40. Ridicule is an effective teaching device with the mentally retarded.
41. Unit rules should be flexible and reflect individual differences in the resident population.
42. It is to be expected that mental retardation workers will have some "favorites" among a unit's retarded residents.
43. Mental retardation workers should point out the differences between the truth and a lie in working with retarded residents.

44. If a resident asks, "Am I retarded", a mental retardation worker should tell him, "No, you're not".

45. The mentally retarded resident should be allowed some opportunities to be alone.

46. The mentally retarded resident in an institution should be treated very much like an inmate in a prison.

47. Mentally retarded residents need affection, attention, respect, and concern for their emotional well being.

48. Mentally retarded citizens should be encouraged to attend community activities with all other members of the community.

49. Mentally retarded residents should be able to determine the length of their hair and what clothes they can wear.

50. Mentally retarded residents should not be allowed to smoke since it is dangerous to their health.

51. Residents should be allowed to form "unit governments" and make many of their own rules.

52. Mental retardation workers should be sure that residents understand all unit rules which apply to resident behavior.

53. Residents can be held accountable for where they are going and what they are doing, when they leave the unit.

54. Mentally retarded residents of a state institution should feel that the employees of that institution are their friends and care for the residents as individuals.
Essay Questions

1. Many residents engage in fist fights and their teeth were even broken during fist fights. How would you stop a fight occurring? How would you intervene before the first punch is thrown?

2. If a resident asked you, "Why am I different from other people?" your reply would be _______________________________________________________.

3. Many retarded citizens have a fear of failure. They often tried to do things that other people do and have failed to achieve success. Joe, a 20 year old man on your unit, is to start a new job placement tomorrow. Tonight he appears nervous and agitated. He has engaged in several shouting matches with other residents. He tells you, "If I get thrown in seclusion, I won't have to go to work tomorrow." What should you do?
4. David is a high functioning retarded man on your unit. He has been placed in many jobs and in training programs but is always "fired" or "washed out" due to his belligerancy and aggressive behavior. He asks you, "Help me to control my temper". You should:

5. Marcella, a 16 year old girl on your unit, has often been seen with many of the older male residents. She tells you that many of these men have "tried to be nasty with me". Nasty means to have sexual intercourse. Marcella enjoys the attention/affection she receives from these men. What should you do?
IV. Purpose of the Module

The purpose of the module is to introduce to the learner the concepts of "active treatment", "least restrictive setting", and "individual habilitation program" as they apply to Unit Life Procedures.

V. Assumptions

VI. Motivational Aspects
VII. Terminal Objective

1.0 - The terminal objective of this exercise is to inform the potential mental retardation worker of the legal rights of the resident and to teach the potential mental retardation worker his role in protecting these rights and his responsibilities in providing those services under the individual habilitation plan.

VIII. Enabling Objective
IX. ATTACHMENTS TO MODULE 6
Post-Test.
The following is a list of the rights of the institutionalized retarded citizen. Following each right is a situation which calls on you as the mental retardation worker to preserve and protect these legal rights. Respond by checking the choice(s) which is/are the most correct way(s) to handle the situation.

A. The right of freedom of choice within the individual's capacity to make decision.

1. Raymond, who works daily in the institution sheltered workshop, refuses to take showers. On this day his lack of hygiene is especially notable. In this situation you should:
   ___a. Physically force Raymond to take a shower.
   ___b. Tell Raymond he cannot go to the workshop unless he takes a shower.
   ___c. Tell Raymond he cannot have his breakfast until he takes a shower.
   ___d. Tell Raymond his smell is most offensive to you and that you prefer not to be around him until he takes a shower.
   ___e. Tell the workshop staff the Raymond "smells like a horse" and that they should straighten him out.

B. The right to live in the least restrictive, individually appropriate environment.

2. Alice, a woman in her forties, lives on a unit with severely and profoundly retarded residents. In working with Alice you find that although she is blind and has a humped back (scoliosis), she is a very social person who has many normal interests. One of these interests is knitting which she learned as a young girl.
However, Alice is not allowed to knit as the other residents may take her knitting needles and injure themselves. You should:

   a. Follow the rules and continue as you have.
   b. Recommend to the supervisor that Alice be transferred.
   c. Refer Alice's problem to the unit social worker or to her habilitation plan case manager.
   d. Teach Alice to crochet or macrame or other activity which does not require the use of pointed needles.
   e. Tie the knitting needles to Alice's arm so that other residents may not steal them.

C. The right of the institutionalized citizen to express themselves verbally, through phone conversations (the resident must pay for toll calls) or through written communication.

3. Cindy, a teenage girl on your unit, takes a great delight from calling you "bubble-ass". For obvious reasons this habit annoys you. You should:

   a. Totally ignore Cindy when she calls you "bubble-ass".
   b. Take Cindy aside and tell her that there are many unattractive things about her but since you're a good person you won't bring them up.
   c. Suggest to the supervisor that Cindy's privileges be suspended until she treats you with proper respect.
   d. Take Cindy aside and tell her in no uncertain terms that you despise that kind of language.
   e. Go on a diet.
D. The right of the resident or guardian to refuse to participate in any phase of the habilitative services.

4. Carl, a man in his sixties, refuses to go bowling with the group the activity therapist takes each Friday afternoon. His only excuse is, "I hate bowling". You should:

   a. Tell Carl he cannot watch T.V. during the time the rest of the residents are bowling.
   b. Talk to Carl about his habilitation plan and tell him that bowling is an important activity which he must do in order to get well.
   c. Respect Carl's wishes.
   d. Tell Carl that he doesn't have to go bowling but that it would make everyone feel better if he did.
   e. Talk to the activity therapist about another activity for Carl.

E. The right to protection against exploitation, demeaning treatment, or abuse.

5. Ignace, a Mental Retardation Worker II, has worked on the unit for a number of years. He has a nickname for each of the residents. Some nicknames are affectionate, "Cupey", "Smiley", and "Sonny". Some are not affectionate, "Burrhead", "Dopey", and "Gimp". The residents don't seem to mind. In fact many call themselves by these names. When you object to the supervisor that you find these names demeaning, he replies, "Oh, Iggy worked here a long time. The residents love him." You should:

   a. Report Ignace to the unit director, going over the supervisor's head.
   b. Make your objection in writing to the supervisor.
c. Begin calling the residents by their first and last names.

d. Forget it.
e. Talk to Iggy yourself and tell him you find his nicknames demeaning.

F. The right to participate in a comprehensive set of habilitative programs appropriate to his or her level of intellectual functioning.

6. Lorretta is a young woman on your unit. She is confined to her wheelchair. She has many jerky movements. You learn that she has a condition known as Cerebral Palsy. Although Lorretta cannot speak, you have learned to understand Lorretta through her gestures and facial expressions. You have also learned through your contact with her that Lorretta is a sensitive person who has a good sense of humor and that she can follow your conversations with her. You also feel that she may benefit from physical therapy. Lorretta has been placed on a unit with profoundly retarded, non-ambulatory residents. She is fed all her meals and diapered. She spends most of her time watching T.V. Twice a week an activity therapist comes to the ward and plays a piano for the residents. An occupational therapist checks her chair once a month and occasionally adds padding to it. She is weighed once a month and sees the doctor irregularly. When you ask the supervisor if you can take Lorretta outside for a walk, she tells you, "No, that's not a good idea. The other patients might want to go out, too". You feel Lorretta could be toilet-trained, taught to feed herself, could benefit from physical therapy, and would probably enjoy movies, walks, and attending social functions. When you talk to the unit social worker about this, he tells you, "Lorretta's
profoundly retarded, and she's on a non-am unit. We have a pretty set habilitation plan for those people. It doesn't include those things". You should:

a. Ask your supervisor if you could be included in the next review of Lorretta's habilitation plan.

b. Start reading up on Cerebral Palsy.

c. Ask the occupational therapist if there are special utensils that can be used to help Lorretta feed herself.

d. Ask Lorretta to tell you when she has to go to the bathroom.

e. Introduce Lorretta to the unit social worker, her habilitation plan case manager, or to your supervisor and explain Lorretta's gestures and facial expressions.
APPENDIX F:

Samples of the Ohio Mental Retardation Information Scale

and the Ward Worker Performance Inventory
APPENDIX F

1. ______ refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period.

2. An individual with mental retardation must demonstrate deficits in both:
   a. _____ intelligence and appearance
   b. _____ attitude and adaptive behavior
   c. _____ adaptive behavior and measured intelligence
   d. _____ measured intelligence and attitude

3. The degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age or culture group is the definition of:
   a. _____ level of functioning
   b. _____ degree of severity
   c. _____ adjustment
   d. _____ adaptive behavior

4. ______ refers to significantly subaverage I.Q. scores as measured by one or more of the standardized tests, such as the Standard Binet test and the Wechsler test.

5. ______ is defined as the effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected of his/her age or culture group.

6. ______ refers to significantly subaverage I.Q. scores as measured by one or more of the standardized aptitude tests.

7. There are four degrees of retardation recognized today. These are ______, ______, ______, and ______.

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8. __________ degree of retardation refers to individuals who are capable of social and vocational adequacy with proper individual training.

9. __________ degree of retardation refers to those mentally retarded individuals who are capable, after appropriate training, of self-maintenance in unskilled or semi-skilled occupations.

10. __________ retarded individuals exhibit gross retardation and need nursing care.

11. __________ retarded individuals exhibit poor motor development and minimal speech and are generally unable to profit from self-help training.

12. __________ and __________ are the two types of causes of mental retardation.

13. Which of the following best describes developmental difficulties which occur during the months of pregnancy:
   a. social deprivation
   b. postnatal
   c. prenatal
   d. perinatal

14. The most common cause of mental retardation during the prenatal period is:
   a. accidents
   b. infections, injuries, medications, poor nutrition
   c. physical injuries to the head
   d. lack of oxygen

15. Shortly after birth (postnatal) the most common cause of mental retardation is:
   a. accidents
   b. lack of nutrition
   c. improper controlled medication
   d. infections; extremely high and uncontrolled fevers, physical injuries to the head
16. The most common cause of mental retardation during birth (perinatal) is:
   a. _____ difficult deliveries; prematurity and cord around the neck
   b. _____ accidents
   c. _____ lack of nutrition
   d. _____ infections

17. Matching (place the correct number by the appropriate definition)
   a. ___ Adaptive Behavior 1. A concept emphasizing that the retarded person
   b. ___ Attendant should have its same basic rights as other
   c. ___ Cerebral Palsy citizens.
   d. ___ Commitment (legal) 2. The application of techniques for the systematic
   e. ___ Day Care Program appraisal of the physical, mental, economic and
   f. ___ Dependent M.R. intellectual resources of an individual.
   g. ___ Developmental Disabilities 3. A public or private facility that provides the
care, treatment, habilitation and rehabilitation
   h. ___ Evaluation of the resident.
   i. ___ Habilitation Programs 4. The care necessary for some profoundly retarded
   j. ___ Individual Functioning individual with major medical problem.
   k. ___ Institution 5. No effectiveness or degree with which the
   l. ___ Least Restrictive individual meets the standards of personal
   Environment independence and social responsibility expected
   m. ___ Life Support Care of him/her.
   n. ___ Normalization 6. A person employed to provide basic care and
   o. ___ Unitization training services to the mentally retarded.
   p. ___ Right to Treatment 7. A disability that is attributable to mental
   retardation, Cerebral Palsy, Epilepsy, etc.
   8. A disorder dating from birth which is non-
   progressive, characterized by paralyses, weakness
   and incoordination.
   9. The ability of the resident to successfully
   accomplish the tasks or activities demanded of
   him by the institutions.
   10. Assignment to custody, confinement or treatment
   by court order.
   11. The process by which a staff of an institution
   assists the resident in acquiring and maintaining
   life skills which enables him to cope more effec-
   tively with the demands of his own person and
   the environment.

(see next page for continuation of matching)
12. Providing optimal training of resident in an environment as free of constraints as possible.

13. The organization of an institution into units that will enhance training of the mentally retarded.

14. The obligation of the State of Ohio to provide opportunities for its mentally retarded.

15. A mentally retarded individual who requires continuing supervision or assistance is his/her social, academic functioning, and daily living.

16. Extended care services provided in the community.

18. There are approximately ______ million mentally retarded in the United States.

19. The ______ and ______ retarded has a population of only about 285,000 individuals.

20. Only ______ % of all retarded in the United States are located in institutions.


22. ______ is responsible for most of our problems.

23. Listed below are examples of ways in which we communicate. Check those which lead to improved communications.

- good taste
- common sense
- interrupt
- use "I", "He" and "My" frequently
- use "You" and "Yours" frequently
- repeat yourself
- use manerisms
- give others a chance to talk
- listen carefully
- be tactful
- laugh at others
- be kind
- make other people feel important
- think before speaking
- pass on confidential information
- say nothing
- pass on rumors
- understand other's point of view
- pass judgment

- know what you are disagreeing with
- ask for details
- argue
- use persuasion in a disagreement
- use name-calling in a disagreement
24. Which of the following is not a skill in communication?
   a. _____ the words we use
   b. _____ the manner in which we express them
   c. _____ talking in a monologue about ourselves
   d. _____ the body movements we use when speaking

25. Why do we ask questions?
   a. _____ to obtain specific information
   b. _____ to get suggestions and ideas
   c. _____ to find out the other persons opinion
   d. _____ to encourage a change in behavior
   e. _____ to emphasize a point
   f. _____ all of the above

26. Listed below are some examples of telephone communications. Check those which are appropriate for the Mental Retardation Worker on the Unit.

   ____ let phone ring several times
   ____ give name, title, and unit when answering
   ____ politely do not ask the caller his name
   ____ address caller by name
   ____ keep pad and pencil near phone at all times
   ____ deliver messages to proper party promptly
   ____ politely do not ask caller to repeat message, even if you are uncertain
   ____ be impersonal and formal
   ____ speak loudly into the speaker

27. The following are examples of rules which can apply to written communications. Check those which lead to improved communications.

   ____ know what you are going to say
   ____ use big words
   ____ a long report is a good report
   ____ spell correctly and use good grammar
   ____ avoid examples
   ____ stick to the subject
   ____ always express your opinion in a factual report
   ____ keep your report interesting and formal
   ____ keep your writing legible
28. The most important responsibility of the attendant is to develop ______________________ with the residents.
   a. _____ good relationships
   b. _____ discipline
   c. _____ authority
   d. _____ control

29. Which of the following are defense mechanisms?
   a. _____ projection
   b. _____ withdrawl
   c. _____ regression
   d. _____ rationalization
   e. _____ need for reassurance
   f. _____ all of the above

30. Which of the following techniques can be used in guiding the resident?
   a. _____ make sure the resident understands what you are saying
   b. _____ avoid being abstract: use simple words
   c. _____ be alert to emotional reactions of resident
   d. _____ provide reasonable directions
   e. _____ stick to one immediate problem
   f. _____ avoid derogatory terms
   g. _____ all of the above

31. Write a statement about your responsibility for confidentiality of the resident's records. (2-3 sentences)
32. Which of the following are appropriate statements to make to the parent or guardian of a resident? (check them)

- "Joey is doing fine"
- "He has learned to feed himself"
- "Your daughter was unmanageable for days after her last home visit with you"
- "Susie does bite herself when upset"
- "Are your emotional problems being treated"
- "I know all about you and your family"
- "Your son drives me crazy"
- "Edward enjoys his trips to the canteen with me"
- "The psychology record says your son has a mental age of 3"

33. If properly trained, you are allowed to communicate the following information about residents to his relatives:

a. _____ none
b. _____ needs and program only
c. _____ information in the resident records only
d. _____ needs, program and information in the records

34. Residents are permitted free and unsupervised use of which of the following?

a. _____ telephone (calling and receiving)
b. _____ opening their own mail and packages
c. _____ sending or receiving mail without censorship
d. _____ all of the above
e. _____ none of the above

35. Habilitation refers to

36. Programming refers to
37. Increase in the frequency of behavior as a result of an environmental consequence is known as ________________.

38. Systematic checking and observation of behavior following prescribed time periods is known as a __________________________________________ procedure.

39. Using environmental contingencies to gradually approach a behavioral criterion is known as ________________.

40. Abilities to toilet, eat, dress, and groom are known as basic __________ skills.

41. Habilitation programming:
   a. ____ is unnecessary with retarded residents
   b. ____ is necessary with retarded residents
   c. ____ is not at all helpful
   d. ____ is useful in all cases without exception
   e. ____ all of the above
   f. ____ none of the above

42. Reinforcement:
   a. ____ refers to increases in frequency of behavior
   b. ____ refers to decreases in frequency of behavior
   c. ____ has no specific reference to behavior
   d. ____ is always necessary following the emission of the specified response
   e. ____ all of the above
   f. ____ none of the above
43. Shaping:
   a. _____ is an unscientific tool
   b. _____ is unnecessary in most instances
   c. _____ is lacking in precision
   d. _____ is a useful tool in teaching complex series of behaviors
   e. _____ all of the above
   f. _____ none of the above

44. Basic self-help skills:
   a. _____ include toileting, dressing, eating, and grooming
   b. _____ refer to skills necessary for happiness in life
   c. _____ frequently require teaching to retarded residents
   d. _____ are basic to performance of other activities in life
   e. _____ all of the above
   f. _____ none of the above

45. With retarded residents:
   a. _____ it is unnecessary to teach community living skills
   b. _____ it is unnecessary to teach job-related skills since most retarded persons are lazy and do not work anyway
   c. _____ it is unnecessary to carefully observe behavior since retarded persons do not do very much
   d. _____ it is unnecessary to provide consistent reinforcement
   e. _____ all of the above
   f. _____ none of the above
46. Intermittent reinforcement:
   a. _____ provides reinforcement on a specified schedule
   b. _____ is good for maintaining a behavior once established
   c. _____ promotes great resistance to extinction
   d. _____ produces a high rate of responding
   e. _____ all of the above
   f. _____ none of the above

47. Punishment:
   a. _____ is a useful tool in dealing with human behavior
   b. _____ should be included in any behavior modification program
   c. _____ does not produce undesirable side effects
   d. _____ results in permanent loss of punished behavior
   e. _____ all of the above
   f. _____ none of the above

48. When drinking liquid from a cup the liquid is:
   a. _____ poured into the mouth
   b. _____ poured over lower lip which moves it to the rear of the mouth for swallowing
   c. _____ poured into the mouth and the tongue then forces it into the throat for swallowing
   d. _____ sucked up from the container

49. Eating problems can occur when a resident has:
   a. _____ a large tongue
   b. _____ a lazy tongue
   c. _____ a tongue thrust
   d. _____ all of the above
   e. _____ none of the above
50. The resident chews very slowly. You should:
   a. ____ give him a small amount of food
   b. ____ allow him to swallow before giving him a second spoonful
   c. ____ feed him pureed food so he doesn't have to chew
   d. ____ a and b
   e. ____ a, b, and c

51. Dressing a handicapped resident daily is:
   a. ____ a step toward normalization
   b. ____ not necessary especially if he is a crib resident
   c. ____ too much work
   d. ____ is a way to teach self-care skills
   e. ____ a and d
   f. ____ b and c

52. When considering toilet training a resident which of the following statements is true?
   a. ____ girls take longer to train than boys
   b. ____ the resident should be punished for accidents
   c. ____ the training must be done on a consistent basis
   d. ____ none of the above

53. Fingernails and toenails should be cut:
   a. ____ every two weeks
   b. ____ once a month
   c. ____ when needed

54. Mouth care for residents should:
   a. ____ be done on a daily basis
   b. ____ prescribed only by a dentist
   c. ____ done only by a nurse
55. The retarded multiple-handicapped child presents:
   a. _____ no feeding problem
   b. _____ group feeding problems
   c. _____ individual feeding problems

56. Two important things to remember when feeding are:
   a. _____ use tablespoons
   b. _____ to have the resident comfortable
   c. _____ to keep the noise level quiet
   d. _____ to feed as fast as possible

57. When providing entertainment for the crib resident the student should provide:
   a. _____ wooden blocks and stick toys
   b. _____ mobiles, plastic squeeze toys
   c. _____ books and soft cuddly toys

58. When entertaining or playing with a group of residents, the student should be aware that this play must be:
   a. _____ partially supervised
   b. _____ no supervision
   c. _____ needs supervision

59. A well planned program for fulfilling leisure time would best be suited for:
   a. _____ leaving the resident in his own environment, ex. own crib
   b. _____ take the resident to another area, would provide better stimulation and motivation for his leisure time
   c. _____ take the resident to another area, leave him to his own interest, provide little or no stimulation to benefit his leisure time
60. When providing materials for use in leisure time, the student must try to:
   
a. _____ obtain and offer material beyond his mental or physical capacity in order for the resident to progress in his development.

b. _____ obtain and offer material that are of his level of retardation

c. _____ offer ideas of his own interest, to acquaint the resident of activities outside the institution

61. When planning activities during leisure time, the student should:
   
a. _____ do as much planning and implementing of the program as his time allows

b. _____ let the resident "do his own thing" without any assistance from staff

c. _____ include the residents own ideas and participation

62. A mentally retardate:
   
a. _____ has no understanding of a higher being

b. _____ has no ability to learn of God

c. _____ has individual spiritual needs as well as physical needs

63. If the employee has strong religious feelings himself:
   
a. _____ he needs to give support to the residents feelings

b. _____ it is his responsibility to teach his beliefs to those who are willing to listen

c. _____ let the resident do as he wishes
64. Put the proper number in the blank.

1. Feces  11. Urethra
2. Scrotum  12. Masturbation
3. Uterus  13. Circumcision
5. Sperm  15. Menses
7. Sperm  17. Rectum
8. Ovary  18. Vagina
10. Clitoris

a. _____ Pouch containing the testicles
b. _____ Pear-shaped organ in the female, where the fetus grow until birth
c. _____ An organ of spongy blood cells by which the baby is attached to the lining of the uterus and through which the fetus is fed and wastes are eliminated
d. _____ Outlet of the rectum
e. _____ Whitish fluid ejaculated by the male at climax, containing male sex cells (in fertile males)
f. _____ Mature reproductive cells of the male which are capable of fertilizing the female ovum
g. _____ Female reproductive cell, which after fertilization begins developing into an embryo
h. _____ Cone-shaped head of the male sex organ
i. _____ Lower part of the large intestine
j. _____ Canal from the external sex organs of the female to the cervix
k. _____ Removal of the foreskin from the penis
l. _____ Female reproductive gland
m. _____ Male sex glands
n. _____ A small, highly sensitive female sex organ located where the inner folds of the vulva meet
o. _____ External sex organs of the female
p. _____ Body wastes discharged by the anus
q. _____ Canal through which urine is discharged
r. _____ Production of orgasm by self-manipulation of genitals
s. _____ Periodic discharge of bloody fluid in the female
65. Senate Bill 336, as amended, is designed to:

a. _____ insure that the mentally retarded people in the State of Ohio retain all the rights that are afforded other citizens
b. _____ prevent inappropriate institutionalization
c. _____ assure appropriate treatment and humanized environments within the institutional setting
d. _____ address the ways in which a citizen may be admitted to or discharged from, an institution
e. _____ all of the above
f. _____ none of the above
g. _____ a and b above

66. As a mental retardation worker, which one of the following expressed purposes of Senate Bill 336 will you most be directly involved with:

a. _____ to promote the human dignity and to protect the constitutional rights of the mentally retarded in the State of Ohio
b. _____ to encourage the development of the ability and potential of each mentally retarded person in the State to the fullest possible extent, no matter how severe his disability
c. _____ to promote the economic security, standard of living, and meaningful employment of the mentally retarded
d. _____ to recognize the need of mentally retarded persons, to live in surroundings and circumstances as close to normal as possible

67. An employee of the Division of Mental Retardation, who deliberately denies a client's civil rights will be subject to disciplinary action and may be:

a. _____ libel to court action
b. _____ libel for slander
c. _____ subject to contract disobedience
d. _____ committing a crime against the State
68. All residents are allowed to:
   a. _____ receive visitors
   b. _____ have reasonable access to telephones
   c. _____ have reasonable access to writing materials and postage
   d. _____ a and b above
   e. _____ all of the above
   f. _____ none of the above

69. Under Senate Bill 336, there are two types of admissions. They are called:
   a. _____ client entrance admissions
   b. _____ community and resident admissions
   c. _____ voluntary and involuntary admissions
   d. _____ parent and court admissions

70. Any person, 18 years of age or older, who may be mentally retarded, or the parent or guardian of said person, who is deemed incompetent, may apply for:
   a. _____ trial visit status
   b. _____ voluntary admission
   c. _____ involuntary admission
   d. _____ discharge

71. The above mentioned type of admission (in question 70) is only approved by the Division of Mental Retardation if:
   a. _____ when the client under consideration truly desires to become a resident
   b. _____ it is in the best interest of the individual who is applying
   c. _____ all tests and evaluations indicate some degree of mental retardation
   d. _____ the parent or guardian approves the admission
72. Under Senate Bill 336, what admission must be made through the Court?
   a. ____ voluntary admissions
   b. ____ trial admissions
   c. ____ involuntary admissions
   d. ____ right to treatment admissions

73. There are two classes of clients who may be admitted, involuntarily, to our State's institutions. They are:
   a. ____ those who represent a substantial danger to themselves and those who represent a substantial danger to the general public
   b. ____ those who represent a substantial danger to themselves and those who are unable to provide for their most basic physical needs
   c. ____ those who represent a problem to the courts and those who represent a problem to the community
   d. ____ those who are without a guardian and those who desire to be admitted

74. Those persons who are moderately, severely, or profoundly retarded may be court committed (involuntarily) only when two other conditions (besides their degree of retardation) are present. These other two conditions are:
   a. ____ when a person represents a substantial danger to himself/herself and is unable to provide for his/her basic needs
   b. ____ adequate community resources are not available
   c. ____ the parent and/or guardian and client agree to be involuntarily committed
   d. ____ a and b above

75. Senate Bill 336 protects the individual client against abuse. Any worker who suspects that a client has been abused or neglected must immediately report this abuse or neglect to the Superintendent. A written report must be filed which describes:
   a. ____________________________________________________________.
   b. ____________________________________________________________.
   c. ____________________________________________________________.
76. The law provides that any person who reports or testifies in an abuse case will have _______________ from civil or criminal prosecution on matters surrounding the alleged incident.

a. ___ protection
b. ___ immunity
c. ___ security
d. ___ all of the above

77. Employees who act reasonably and in good faith upon actual or thought to be reliable knowledge (of an abuse incident), are free from financial liability from clients or others bringing suit for alleged mistreatment of clients. This provision, in the law (5123.91) DOES NOT protect employees whose actions:

a. ___ are susceptible to criminal prosecution
b. ___ are planned
c. ___ thought out
d. ___ without consequence

78. A client may not perform labor for the support and maintenance of the facility without receiving ____________ in accordance with the Fair Labor Standard Act.

a. ___ wages
b. ___ free time
c. ___ free lunches
d. ___ overtime

79. The client’s Individual Habilitation Plan (IHP) is a plan which will assist the resident in their:

a. ___ maximum adjustment to the community
b. ___ maximum adjustment to the institutional environment
c. ___ maximum social, emotional and/or physical development
d. ___ daily activities
80. The correct definition of an Individual Habilitation Plan is:
   a. _____ a plan for the daily work activities of the resident
   b. _____ a plan for administering medication to the resident
   c. _____ a plan that will help the resident receive maximum social, emotional and physical development
   d. _____ a "last resort" plan for the resident before he becomes confined to the institution for life

81. The right of freedom of choice within the individual's capacity to make decision.
   A. Raymond, who works daily in the institution sheltered workshop, refuses to take showers. On this day his lack of hygiene is especially notable. In this situation you should:
      1. _____ physically force Raymond to take a shower
      2. _____ tell Raymond he cannot go to the workshop unless he takes a shower
      3. _____ tell Raymond he cannot have his breakfast until he takes a shower
      4. _____ tell Raymond his smell is most offensive to you and that you prefer not to be around him until he takes a shower
      5. _____ tell the workshop staff that Raymond "smells like a horse" and that they should straighten him out

82. The right to live in the least restrictive, individually appropriate environment.
   B. Alice, a woman in her forties, lives on a unit with severely and profoundly retarded residents. In working with Alice you find that although she is blind and has a humped back (scoliosis), she is a very social person who has many normal interests. One of these interests is knitting which she learned as a young girl. However, Alice is not allowed to knit as the other residents may take her knitting needles and injure themselves. You should:
      1. _____ follow the rules and continue as you have
      2. _____ recommend to the supervisor that Alice be transferred
      3. _____ refer Alice's problem to the unit social worker or to her habilitation plan case manager
      4. _____ teach Alice to crochet or macrame or another activity which does not require the use of pointed needles
      5. _____ tie the knitting needles to Alice's arm so that other residents may not steal them
83. The right of the institutionalized citizen to express themselves verbally, through phone conversations (the resident must pay for toll calls) or through written communication.

C. Cindy, a teenage girl on your unit, takes a great delight from calling you "bubble-ass". For obvious reasons this habit annoys you. You should:

1. _____ totally ignore Cindy when she calls you "bubble-ass"
2. _____ take Cindy aside and tell her that there are many unattractive things about her but since you are a good person you won't bring them up
3. _____ suggest to the supervisor that Cindy's privileges be suspended until she treats you with proper respect
4. _____ take Cindy aside and tell her in no uncertain terms that you despise that kind of language
5. _____ go on a diet

84. The right of the resident or guardian to refuse to participate in any phase of the habilitative services.

D. Carl, a man in his sixties, refuses to go bowling with the group the activity therapist takes each Friday afternoon. His only excuse is, "I hate bowling". You should:

1. _____ tell Carl he cannot watch T.V. during the time the rest of the residents are bowling
2. _____ talk to Carl about his habilitation plan and tell him that bowling is an important activity which he must do in order to get well
3. _____ respect Carl's wishes
4. _____ tell Carl that he doesn't have to go bowling but that it would make everyone feel better if he did
5. _____ talk to the activity therapist about another activity for Carl

85. The right to protection against exploitation, demeaning treatment, or abuse.

E. Ignace, a Mental Retardation Worker II, has worked on the unit for a number of years. He has a nickname for each of the residents. Some nicknames are affectionate, "Cuppy", "Smiley", and "Sonny". Some are not affectionate, "Gurrhead", "Dopey", and "Gimp". The residents don't seem to mind. In fact many call themselves by those names. When you object to the supervisor that you find these names demeaning, he replies, "Oh, Iggy has worked here a long time. The residents love him". You should:

1. _____ report Ignace to the unit director, going over the supervisor's head
2. _____ make your objection in writing to the supervisor

(continued on next page)
3. _____ begin calling the residents by their first and last names
4. _____ forget it
5. _____ talk to Iggy yourself and tell him you find his nicknames demeaning

86. The right to participate in a comprehensive set of habilitative programs appropriate to his or her level of intellectual functioning.

F. Lorretta is a young woman on your unit. She is confined to her wheelchair. She has many jerky movements. You learn that she has a condition known as Cerebral Palsy. Although Lorretta cannot speak, you have learned to understand Lorretta through her gestures and facial expressions. You have also learned through your contact with her that Lorretta is a sensitive person who has a good sense of humor and that she can follow your conversations with her. You also feel that she may benefit from physical therapy.

Lorretta has been placed in a unit with profoundly retarded, non-ambulatory residents. She is fed all her meals and diapered. She spends most of her time watching T.V. Twice a week an activity therapist comes to the ward and plays a piano for the residents. An occupational therapist checks her chair once a month and occasionally adds padding to it. She is weighed once a month and sees the doctor irregularly. When you ask the supervisor if you can take Lorretta outside for a walk, she tells you, "No, that's not a good idea. The other patients may want to go out, too".

You feel Lorretta could be toilet-trained, taught to feed herself, could benefit from physical therapy, and could probably enjoy movies, walks, and attending social functions. When you talk to the unit social worker about this, he tells you, "Lorretta's profoundly retarded, and she's on a non-ambulatory unit. We have a pretty set habilitation plan for these people. It doesn't include those things". You should:

1. _____ ask your supervisor if you could be included in the next review of Lorretta's habilitation plan
2. _____ start reading up on Cerebral Palsy
3. _____ ask the occupational therapist if there are special utensils that can be used to help Lorretta feed herself
4. _____ ask Lorretta to tell you when she has to go to the bathroom
5. _____ introduce Lorretta to the unit social worker, her habilitation plan case manager, or to your supervisor and explain Lorretta's gestures and facial expressions
87. ______ copies of incident forms are completed for any injury or incident involving a resident or employee.
   a. two
   b. three
   c. one

88. The purpose of restraining and/or holding a resident is to manage the resident's behavior without:
   a. _____ hurting yourself
   b. _____ hurting other residents
   c. _____ causing harm to the resident and/or yourself and others
   d. _____ hurting the resident's pride

89. Restraint of a patient should be:
   a. _____ used by nurses
   b. _____ used as a last resort
   c. _____ used by supervisors
   d. _____ used by a medical personnel

90. Name the three types of restraining holds used when one attendant is present.
   a. _____________________________
   b. _____________________________
   c. _____________________________

91. When a resident is assaultive and has a weapon (knife, fork, club, chair, etc.) an attendant: (circle correct response)
   a. Does/Does not, attempt to get a weapon away from a resident
   b. Does/Does not, get the assistance of another aide and try and cover the weapon with a towel, blanket or sheet
   c. Does/Does not, in an extreme emergency with a very dangerous weapon, covers the resident with a blanket, sheet, etc.
   d. Does/Does not, try and handle the situation himself/herself.
97. What are the procedures used in freeing yourself from a resident who is pulling your hair (from the rear)?
   a. ___________________________.
   b. ___________________________.

98. An aide should check all residents in restraints:
   a. ___ every 30 minutes
   b. ___ every hour
   c. ___ every 2 hours

99. A resident should have his restraints loosened ________ for ambulation, toileting, and fluids.
   a. ___ every 2 hours
   b. ___ once during each shift
   c. ___ every 30 minutes
   d. ___ when aide has time

100. How often should orders for restraints be reviewed and renewed?
    a. ___ bi-annual
    b. ___ monthly
    c. ___ every week
    d. ___ not necessary to renew

101. In the Heimlich Maneuver, foreign material is forced out of the air passage by a quick upward thrust of the victim:
    a. ___ chest
    b. ___ upper abdomen
    c. ___ lower abdomen
102. First aid for poisoning by mouth includes:
   a. _____ induce vomiting
   b. _____ dilute poison with water or milk
   c. _____ observe victim for symptoms of poisoning
   d. _____ call doctor if victim becomes unconscious

103. The first step an aide should perform to control bleeding from a deep laceration is?
   a. _____ direct pressure and elevation
   b. _____ tourniquet
   c. _____ apply dressing
   d. _____ apply pressure to pressure point'

104. To control bleeding, the first step a first aider should take is:
   a. _____ to apply a tourniquet
   b. _____ to apply direct pressure to the site of bleeding
   c. _____ to apply pressure to pressure point
   d. _____ to apply ice pack to site of injury

105. A sterile dressing is placed on a wound:
   a. _____ to keep wound from becoming infected
   b. _____ absorbs drainage
   c. _____ protects wound from further injury
   d. _____ all of the above

106. Which of the following are symptoms of diabetes?
   a. _____ polydypsia, polyuria, polyphagia
   b. _____ loss of weight, acetone breath
   c. _____ increases sugar in blood
   d. _____ all of the above
107. To control bleeding what two things may be necessary to do?
   a. __________________________________________
   b. __________________________________________

108. Involuntary passage of the urine is called:
   a. _____ Cystitis
   b. _____ Gastritis
   c. _____ Incontinence
   d. _____ Ureters

109. Diabetes Mellitus:
   a. _____ is hereditary
   b. _____ is not hereditary

110. A resident in a diabetic coma will have:
   a. _____ pale, moist, cool skin
   b. _____ symptoms of shock and high blood sugar
   c. _____ drowsiness, flushed, hot, dry skin, fruity odor on breath

111. Insulin is manufactured in the:
   a. _____ liver
   b. _____ gall bladder
   c. _____ pancreas

112. A common and serious complication of diabetes is:
   a. _____ heart disease
   b. _____ Jaundice
   c. _____ infection
   d. _____ high blood pressure
113. A resident displays symptoms of excessive thirst, frequent urination, increased appetite and sweet odor on breath. The aide would remember these symptoms of:
   a. ___ Epilepsy
   b. ___ Diabetes Mellitus
   c. ___ Amebiasis
   d. ___ Hepatitis

114. What would you do for a resident who is having a seizure?

115. Which of the following would the aide not do while attending a resident having a grand mal seizure?
   a. ___ loosen clothing around neck
   b. ___ hold resident's head to one side
   c. ___ restrain resident's movements
   d. ___ move furniture from immediate area

116. Seizures that are characterized by severe muscle contractures of the entire body and unconsciousness is what type?
   a. ___ petit mal
   b. ___ grand mal
   c. ___ psychomotor

117. In caring for a seizure victim name two important precautions you would take:
   a. ____________________________________________
   b. ____________________________________________
118. A momentary warning to the resident just before a seizure occurs:
   a. ___ coma
   b. ___ aura
   c. ___ aroma
   d. ___ anecdote

119. A resident fell during a seizure striking his head on the floor. The aide should beware of which symptoms that may indicate a head injury:
   a. ___ pupils unequal in size
   b. ___ vomiting
   c. ___ bleeding from nose, ear canal, or mouth
   d. ___ blood in urine
   e. ___ a, b, and c
   f. ___ a, b, and d
   g. ___ b, c, and d
   h. ___ all of the above

220. The most effective procedure you can do to avoid spreading infections is:
True and False (Mark T for True and F for False)

1. ___ All retarded persons look abnormal
2. ___ Mental Retardation is a disease
3. ___ Mentally retarded individuals are criminals
4. ___ Mentally retarded individuals cannot be trained
5. ___ The mentally retarded have special needs just like everyone else
6. ___ listening is less important than speaking
7. ___ high levels of noise can lead to hearing loss
8. ___ the acoustics of a room, loud noises, poor ventilation, and uncomfortable temperatures are all barriers to listening
9. ___ speaking very slowly and softly will help the listener hear you
10. ___ the ability to concentrate requires mental effort
11. ___ people are more interested in themselves than other people
12. ___ people can listen at a faster rate than people talk
13. ___ listening is a minor part of conversation
14. ___ listening is the first step to persuasion
15. ___ listen to the content, not the manner
16. ___ each resident should be thought of and worked with as an individual
17. ___ personality types do not vary much among the retarded
18. ___ the M.R. Worker should supervise, direct and control the resident
19. ___ the M.R. Worker should guide and influence the residents
20. ___ always give large amounts of attention to those residents which are your favorites
21. ___ never show hostility or rejection
22. ___ accept the resident as he is
23. ___ behavior outbursts are the result of bad temper
24. ___ in order to work with the retarded, you have to be able to detach yourself from your work
25. ___ residents often show immature personality characteristics as a result of their disability
26. ____ M.R. Worker should give psychotherapy when needed

27. ____ confidentiality is violated if you discuss residents with your family and neighbors

28. ____ confidentiality of resident records is protected by law (S.B. 336)

29. ____ confidentiality is violated if you discuss resident records with the resident’s family

30. ____ you may release information on request to any person without permission of the resident or guardian

31. ____ if you accidentally deface or lose a unit record on a resident, it does not have to be reported

32. ____ Habilitation programming is only for retarded persons and would not be helpful for persons of normal intelligence

33. ____ Habilitation does not refer to skills necessary for living

34. ____ A well-designed plan is necessary in order that proper habilitation occur

35. ____ Teaching from an habilitation plan should be measured in small steps

36. ____ It is unimportant for consistent consequences of a positive nature to follow the emission of a particular behavior

37. ____ Habilitation planning only includes those behaviors associated with personal needs and does not deal with social or vocational behaviors

38. ____ A proper habilitation plan specifies behavioral objectives and means for attaining them

39. ____ The resident you are bathing is severely retarded therefore it is not necessary to provide privacy

40. ____ A common cold is caused by a virus

41. ____ Enemas are given only to empty the bowel

42. ____ Tonsillitis may be caused by streptococcus

43. ____ Heart attacks are always fatal

44. ____ The normal body temperature is 98.6°F

45. ____ The temperature may be taken axillary

46. ____ Hot water bottles may be applied to a resident anytime

47. ____ Normal blood pressure is your age/100

48. ____ Vital signs are signs of illness

49. ____ Anatomy is the study of the structure of the body
Due to the mentality of retarded people, there is no need for time and money to be spent working with the spiritual needs of institutionalized individuals.

Religious activities of a mental retardation institution involve just church services on Sunday and special holidays.

Because of the mentally retarded's inability to distinguish or match colors, it is only necessary for effort to be made on the educable mentally retarded.

A child living in a dormitory with only physical needs taken care of, has the same rate of emotional development as a mentally retarded of the same I.Q. level living at home.

The "good" residents who sleeps a great deal, is quiet when awake, and is so easy to care for, has need for a stimulating environment more than the hyperactive resident.

Better counseling for parents and educational progress implemented by the community would prevent a vast majority of the mentally retarded from being placed within an institution.

Persons hired to work with residents within institutions for the retarded, must be in agreement with the principles set forth in Senate Bill 336, and will conscientiously protect the rights of the clients.

An employee of an institution may be named guardian of a client who resides in the institution.

Potential clients are eligible for court commitment even when provisions for meeting their needs are available in the community.

Most retarded can't understand the language so they need not be told of their habilitation plans.

There is no need to explain the purpose of activities and training programs to the retarded.

The retarded person wets and soils himself, it is proper to isolate that person in a locked room.

The retarded have a right to worship God.

The physical welfare of the resident must be safeguarded during research projects.

It is appropriate for several retarded people to share a closet or dresser.

Non-ambulatory residents who are kept in bed most of the day need to be fully dressed.

Since retarded citizens often cannot describe their physical ailments it is important for the mental retardation worker to be especially alert to any change in their appearance or manifestation of pain.
67. ___ When one retarded resident strikes another resident he must be automatically placed in seclusion or isolation.

68. ___ A resident can refuse to go to school or to attend an activity.

69. ___ A resident can refuse to attend a religious service.

70. ___ Mildly to moderate retarded residents can be housed in a living area with profoundly retarded residents.

71. ___ Residents or guardians can refuse to take part in research projects.

72. ___ If a retarded resident receives no treatment or habilitation, the hospital superintendent and other responsible parties can be found to be in violation of the law. (S.B.336)

73. ___ Considering the rights of the mentally retarded it is obvious that legally the retarded are considered to not be able to make decisions concerning their welfare.

74. ___ Retarded citizens do have the same rights as any other citizen plus several more if they are institutionalized.

75. ___ It is appropriate to call residents by any nickname if that resident likes the nickname.

76. ___ Since institutionalized retarded residents are "wards of the state" they have the right to receive only those services that the state can afford to provide.

77. ___ The superintendent of a state hospital can decide on his own what is the best possible treatment for the residents in his charge.

78. ___ A unit supervisor worker can decide on his or her own initiative what the best possible treatment is for the resident in his charge.

79. ___ A mental retardation worker cannot decide on his or her own initiative what the best possible treatment is for the residents in his charge.

80. ___ Mentally retarded residents can never be responsible for their own behavior and actions.

81. ___ The mental retardation worker must follow orders from his immediate supervisor even if those orders are in violation of the residents rights.

82. ___ Mentally retarded citizens really are not citizens and really should not have any rights.

83. ___ You are walking across the street. You are struck by an automobile. You suffer a massive cerebral hemorrhage. You suffer significant brain damage. You are totally incapacitated. You are placed in an institution. You are housed on an non-ambulatory unit, with severely and profoundly retarded residents. You should have no legal rights.
84. As a mental retardation worker you will often have to protect the rights of the mentally retarded.

85. All residents, regardless of age, interests or disability should be sent to bed at the same hour.

86. All residents should be gotten out of bed each morning at the same hour.

87. Mentally retarded citizens should be allowed to take reasonable risks.

88. The mentally retarded should be encouraged to form relationships with the opposite sex.

89. The mentally retarded should be protected from failure.

90. The mentally retarded should be allowed to be sexually deviant.

91. The mentally retarded should always be humored and allowed to get their way.

92. You should never tell a retarded that you disapprove of his or her behavior.

93. A mental retardation worker should never strike a retarded resident.

94. If a mental retardation worker does strike a mentally retarded resident, he or his co-worker should immediately report the incident to his immediate supervisor.

95. Mental retardation workers should never discipline a resident.

96. It is often necessary to repeat a request to a mentally retarded resident as the resident often has difficulty understanding requests or instructions.

97. It is appropriate to discuss a resident's behavior with your supervisor or co-worker while the resident is within hearing range.

98. Ridicule is an effective teaching devise with the mentally retarded.

99. Unit rules should be flexible and reflect individual differences in the resident population.

100. It is to be expected that mental retardation workers will have some "favorites" among a unit's retarded residents.

101. Mentally retarded citizens should be encouraged to attend community activities with all other members of the community.

102. Mentally retarded residents should be able to determine the length of their hair and what clothes they can wear.
103. Mentally retarded residents should not be allowed to smoke since it is dangerous to their health.

104. Residents should be allowed to form "unit governments" and make many of their own rules.

105. "Let the punishment fit the crime" is a good rule to follow in disciplining residents.

106. Mental retardation workers should be sure that residents understand all unit rules which apply to resident behavior.

107. Residents can be held accountable for where they are going and what they are doing, when they leave the unit.

108. Mentally retarded resident of a state institution should feel that the employees of that institution are their friends and care for the residents as individuals.

109. Mental retardation workers should point out the difference between the truth and a lie in working with the retarded resident.

110. If a resident asks, "Am I retarded?", a mental retardation worker should tell him, "No, you're not".

111. The mentally retarded resident should be allowed some opportunities to be alone.

112. The mentally retarded resident in an institution should be treated very much like an inmate in a prison.

113. Mentally retarded residents need affection, attention, respect, and concern for their emotional well being.

114. An acting out resident means a resident who tries to initiate the aide.

115. When a resident acts out this means that the aide has failed on his/her job.

116. To ask for help from other employees or supervisors when you are confronted with a violent resident is not an acceptable procedure.

117. The reasons for self-abusive behavior are the same for all residents.

118. Keeping a calm cool head will get the job done without injury to staff or resident when proper procedures are followed.

119. The staff psychologists should be notified to find out why a resident attempts suicide.

120. It is imperative that residents know that suicide will not be tolerated by anyone.

121. A suicide victim should be made to feel ashamed.

122. Heat, such as in warm, moist compresses, promotes drainage to an area.
Residents clothing should be marked with first then last name.

Eating skills such as chewing, swallowing and sucking are important to the development of speech.

Amoebiasis is found in the stool of an infected person and spread by contaminated hands, food and dishes.
WORKER PERFORMANCE INVENTORY

NAME OF EVALUATOR: ___________________________ DATE OF EVALUATION: ____________________

WORKER RECEIVING EVALUATION: ___________________________

THIS EVALUATION IS BASED UPON MY SUPERVISING THIS WORKER FOR _________________________ (months or days)

SIGNATURE OF EVALUATOR: ___________________________ SIGNATURE OF EVALUATEE: ___________________________

PLEASE RESPOND BY MARKING AN "X" AT THE MOST APPROPRIATE RESPONSE

THIS ATTENDANT:

1. When the worker is assigned to direct-care work with residents, how much of this time does he actively spend working with the resident?

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2. Converses or talks appropriately with the residents.

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3. Spends part of his/her time teaching the residents on the unit those tasks necessary for them to learn in order to function more independently.

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4. Shows respect of the resident's individual rights as people.

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5. Uses correct terminology in describing the resident's behavior and/or condition.

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6. Responds appropriately (comforts, supports, etc.) to the emotional needs of the resident.

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<th>Seldom</th>
<th>Generally</th>
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7. Carries out his/her unit tasks expected by his/her supervisor.

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<th>Poorly</th>
<th>Average</th>
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8. Does more than is expected of him/her without being told. (demonstrates initiative)

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9. Has the ability to function in the absence of direct supervision.

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10. Has the skills to function in the absence of direct supervision.

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11. Has a positive attitude to function and adapt to the demands of the job.

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12. Cooperates with his/her fellow workers and other institution employees.

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13. Follows the institution and unit rules.

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14. Independently controls and directs the correct behavior of the residents under his/her responsibility.

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15. Follows the correct procedures for resident safety (correct techniques of injury-prevention)

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16. Follows the correct procedures for preventing injury to self and others.

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17. Functions effectively in an emergency situation.

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18. Accomplishes the daily housekeeping procedures of his/her unit.

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19. Interacts appropriately with a particular resident's family; other unit visitors; and, the general public.

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20. Adequately meets the requirements of his work schedules.

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APPENDIX G:
Ohio Department of State Personnel
Psychiatric Aide I and II Classification Series

353
APPENDIX G

OHIO DEPARTMENT OF STATE PERSONNEL

PSYCHIATRIC AIDE I

NATURE OF WORK IN THIS CLASS

This is introductory patient care of mentally ill, mentally retarded, and/or geriatric patients.

An employee in this class is responsible for performing routine duties in accordance with established rules and procedures or on specific directions and/or orders from psychiatric aides of higher grade, LPN's, registered nurses, physicians, or other designated professional staff members such as Social Workers or Psychologists. Work is supervised and reviewed by psychiatric aides of higher classification, LPN, RN, physician, or designated Unit or Program Director.

ILLUSTRATIVE EXAMPLES OF WORK

Observation of the patient, notifying Psychiatric Aides of a higher classification, LPN, RN, or physician of any unusual development.

Observation of psychiatric procedures.

Showering, simple tub bathing, shaving, and dressing patients.

Taking temperature, pulse, respiration, and blood pressure. Record and chart same.

Escort patients to clinics, meals, and other hospital activities, as O.T., R.T., and religious services.

Diversions! recreation activity with observation of patient during such activity accompanied by accurate and objective reporting.

Prepare basic reports such as Ward Log, Census Report, Seclusion Records, and Escape Reports.

Recognition of patients' physical needs.

Order and issue linens.

May be required to perform routine and emergency housekeeping duties on a ward.

ESSENTIAL KNOWLEDGES, ABILITIES, AND SKILLS

Basic knowledge of the principles of patient care, especially in respect to feeding, bathing, and dressing mentally ill, mentally retarded, and/or geriatric patients.

Basic knowledge of human anatomy.

Ability to accurately report patients behavior and physical condition.
Knowledge of the institutional and departmental rules and regulations related to patient care.

Ability to follow oral and written directions in exact detail.

Ability to maintain a therapeutic attitude toward patients.

Good physical condition and emotional stability.

QUALIFICATIONS

For positions in the Department of Mental Health and Mental Retardation, must have successfully completed the departmental course of Psychiatric Aide In-service Training.

The class specification which appears above is intended to be sufficient merely to identify the class and be illustrative of the kinds of duties that may be assigned to positions allocated to the class and should not be interpreted to describe all of the duties performance of which may be required of employees holding a position assigned to this class.
OHIO DEPARTMENT OF STATE PERSONNEL

4052

PSYCHIATRIC AIDE II

NATURE OF WORK IN THIS CLASS

This is advanced patient care of mentally ill, mentally retarded, and/or geriatric patients.

An employee in this class is responsible for performing routine duties in accordance with established rules and procedures or on specific directions and/or orders from psychiatric aides of higher grade, LPN's, RN, physician, or other designated professional staff member such as Social Workers or Psychologists. Work is supervised and reviewed by psychiatric aides of higher grade, LPN, RN, physician, or designated Unit or Program Director.

ILLUSTRATIVE EXAMPLES OF WORK

Assist Psychiatric Aide I's in the proper performance of their duties.

Assist professional staff with various types of psychiatric procedures as insulin, electric shock, and drug therapies by preparing the patient and recording and charting same.

Observation of the patient, notifying Psychiatric Aides of higher classification, registered nurse, or physician of any unusual development.

Assist with bed baths, shave, and dress patients.

Recognition of vital signs.

Assist with the care of bedridden patients.

Recognition of physical and emotional needs of patients.

Prepare reports such as Behavior Reports, Ward Log, Census Report, Seclusion Records, and Escape Reports.

Assist with application of restraints.

Escort patients to clinics, meals, and other hospital activities such as O.T., R.T., and religious services. Participate actively with patient in such allied therapies. Observation of patient during such activities accompanied by accurate and objective reporting.

May be required to perform routine and emergency housekeeping duties on a ward.

Performs patient care functions.

ESSENTIAL KNOWLEDGE, ABILITIES, AND SKILLS

Knowledge of the principles of patient care, especially in respect to feeding, bathing, and dressing mentally ill, mentally retarded, and/or geriatric patients.

Revised 4/24/73
Basic knowledge of the symptoms, characteristics, and methods of treatment of the more common psychotic conditions.

General knowledge of human anatomy.

Ability to accurately report patients' behavior and physical condition.

Knowledge of the Institutional and Departmental rules and regulations related to patient care.

Ability to follow oral and written directions in exact detail.

Ability to maintain a therapeutic attitude toward patients.

Some skill in the use of sterile technique and use of medical apparatus.

Good physical condition and emotional stability.

QUALIFICATIONS

For positions in the Department of Mental Health and Mental Retardation, must have successfully completed the departmental course of Psychiatric Aide II training and served one year of continuous service as a Psychiatric Aide I.

The class specification which appears above is intended to be sufficient merely to identify the class and be illustrative of the kinds of duties that may be assigned to positions allocated to the class and should not be interpreted to describe all of the duties performance of which may be required of employees holding a position assigned to this class.
APPENDIX H:

Commissioner's Request for Staff Development Materials
October 6, 1975

Mailed to All State's Comissioner's

Dear

Recent developments within the State of Ohio have dictated that new inservice training programs, for personnel working in institutional wards, be developed. Moreover, the correct training of ward personnel that will later become supervisors has also been mandated. I would very much appreciate receiving a copy of your training packages for the two separate categories outlined above, plus other information you feel might be relevant. It would assist me, and my committee, a great deal in the development and maintenance of appropriate standards for Ohio.

As usual, time is of the essence. I would appreciate hearing from you at your earliest convenience. If there is a charge for the two above-mentioned programs, please bill us.

Sincerely,

Norman J. Niesen, Ed.D
Commissioner

cc: Michael J. Elsberry, Assistant to the Commissioner
APPENDIX I:

Director of the Department of Mental Health and Mental Retardation

Executive Committee on Training
TO: Milton W. McCullough, Assistant Commissioner
Office of Education and Training

FROM: Norman J. Niesen, Ed.D.
Commissioner

SUBJECT: Committee Assignments for Development of Training Programs for Mental Retardation Aides I and II

I apologize for my delay in assembling names for the committee to develop a training and education program for the new classification of Mental Retardation Aides I and II. It is understood that the new classification will replace the Psychiatric Aide I and II classification for staff employed in Mental Retardation Facilities. Further, it is agreed that some of the content of the existing Psychiatric Aide Training Programs may be found appropriate for inclusion in the new training program.

May I suggest the following names for the Task Force Committee. All names preceded by an asterisk have been cleared with the appointing authority:

*Dr. Louis A. Mazzoli
*Mr. Michael J. Fisberry
Mr. George Kloury
Ms. Barbara Heretta
Mr. John Santose
Mrs. Laura Cormwell
Mrs. Louise Hustak
Mr. Robert Moorehead
Mr. Michael LaFuda

Central Office
Orient State Institute
Columbus State Institute
Apple Creek St. Institute
Gallipolis State Institute
Broadview Center
Education and Training

On the Project's Executive Committee may I suggest to you the following:

Dr. Milton McCullough
Dr. Norman Niesen
Dr. Bernard Nieman
Dr. Maxine Mays

Dr. Louis Mazzoli
Dr. Roger Gove
Mr. Robert Moorehead

Staff to the Executive Committee will be Michael Elsberry

NJH/JSr

cc: All the Above
December 26, 1975

Mr. Michael J. Elsberry  
Assistant to the Commissioner  
Division of Mental Retardation  
and Developmental Disabilities  
2929 Kenny Road/Room B105  
Columbus, Ohio 43221

Dear Mr. Elsberry:

As Chairman of the Task Force Executive Committee on development of effective training programs for direct-care personnel in Ohio's institutions, I want to commend you on a job well done. The members of the Executive Committee, and I, accept what you refer to as "content categories," contingent upon their final review by your Expert Panel.

Please convey my thanks to your Task Force; and, good luck in the testing of the proposed curriculum.

Sincerely,

[Signature]

NORMAN J. NIESEN, Ed.D.  
Commissioner

cc: Task Force Executive Committee Members  
Dr. Louis A. Mazzoli, Assistant Commissioner  
Mr. Joseph A. Aubberger, Assistant Commissioner
December 16, 1975

Mr. Michael J. Elsberry
Assistant to the Commissioner
Division of Mental Retardation
and Developmental Disabilities
2929 Kenny Road/Room B105
Columbus, Ohio 43221

Dear Mr. Elsberry:

I have received your Worker I curriculum categories, and find them outstanding. It appears that your Task Force has given a great deal of time and effort to these modules; and, I feel they will enhance the development of attendants in our state institutes for the mentally retarded.

I have no recommendations for change at this time; nor do I have additions to recommend on any of the six modules. I would, however, appreciate a copy of the comments that your Expert Panel submits to you.

Moreover, please indicate to your Task Force that they have fulfilled a much-needed priority in this State. When I have met with them in the past, they have exhibited a great deal of knowledge, plus the necessary motivation to "get the job done." In addition, I wish you personal success in your efforts to validate the curriculum modules.

Cordially yours,

LOUIS A. MAZZOLI
Assistant Commissioner

cc: Task Force Executive Committee Members
    Dr. Norman J. Niesen, Commissioner
December 29, 1975

Mr. Michael J. Elsberry
Assistant to the Commissioner
Division of Mental Retardation
and Developmental Disabilities
2929 Kenny Road
Columbus, Ohio 43221

Dear Mr. Elsberry:

Thank you for the opportunity to review the categories you plan to utilize in the development of your ward worker curriculum. They appear quite adequate to me, and, in recent discussion with Dr. Niesen, he has also indicated his personal acceptance of each of the modules.

I feel you have covered the spectrum of experiences necessary for an effective ward worker training program, and have no additions to make at this time. In fact, I'm hoping you begin testing your curriculum in the very near future (and make any appropriate revisions); since, as you know, we have lacked an effective training program in Ohio for a number of years.

Sincerely yours,

[Signature]

JOSEPH A. ALGERER
Assistant Commissioner

cc: Dr. Norman J. Niesen, Commissioner
Executive Committee Members
Mr. Terry Hendrick  
Program Director  
Tiffin M.P. Unit  
Tiffin, Ohio 44883

Dear Mr. Hendrick:

This letter is to officially appoint you to the Task Force on development of appropriate training programs for Mental Retardation Workers I and II, and Mental Retardation Supervisors. Welcome to Ohio, and I hope you enjoy your work at Tiffin, and on the Task Force.

Meetings of the Task Force, for the remainder of this year are as follows:

c. Thursday, December 13, 1975.
d. Tuesday, December 23, 1975.

Meetings commence at 10:00 a.m. and usually adjourn at approximately 2:00 p.m. They are held in room D203.

Sincerely yours,

Norman J. Niesen, Ed.D.  
Commissioner

cc: Michael J. Elsberry, Assistant to the Commissioner  
Robert Moorehead, Office of Staff Development  
Michael Lebow, Office of Staff Development  
Louie Maczoli, Chief, Operations North  
George Ahouay, Orient State Institute  
John Snitowski, Apple Creek State Institute  
Barbara Mirbach, Columbus State Institute  
Louise Huntak, Broadview Center  
Laura Cornelius, Gallipolis State Institute
APPENDIX J:

Nationwide Responses to the Commissioner's Request for Staff Development Materials
October 21, 1975

Norman J. Niesen, Ed.D.
Commissioner
Division of Mental Retardation
and Developmental Disabilities
2929 Kenny Road, Room B105
Columbus, Ohio 43221

Dear Dr. Niesen:

This is to acknowledge the receipt of your letter of October 6, 1975. I am forwarding a copy to each of our Mental Retardation Regional Directors. They, in turn, will be able to send you material on their respective training programs.

If we can be of further assistance in this matter, please feel free to contact us.

Sincerely,

Jerry Thrasher, Director
Division of Mental Retardation

cc. Mr. Dennis Griffith
    Lurleen B. Wallace Developmental Center
Dr. Robert Sanders
    Partlow State School and Hospital
Mr. Lindsay Puckett
    Albert P. Brewer Developmental Center
Dear Dr. Niesen:

This is in reply to your request for our staff development training packages. At this time, we are in the process of restructuring inservice training for incoming employees. Because of the modifications and revisions being made in our curriculum our usual lesson plans are in disarray. I am enclosing a copy of our New Employee Orientation schedule and a curriculum guide for our basic behavior modification course. In addition to these two there are several other curriculum modules. They are:

(A) Tools and Techniques of Communication  
(B) Physical Care  
(C) Management of Emergencies  
(D) Concepts of Mental Illness  
(E) Concepts of Mental Retardation  
(F) Drug Therapy  
(G) Treatment Approaches  
(H) Observation and Recording

The above modules are in the process of development and are not finalized at this time. They should be completed within 60 days and may be of some benefit to you at that point.

Our supervisory training, with the exception of occasional workshops, classes, discussions, seminars, etc., is pretty much limited to the American Management Association curriculum. Our last supervisory management course was, "Developing Supervisory Leadership Skills." You may obtain information concerning this program by writing: AMERICAN MANAGEMENT ASSOCIATION, INC., 1819 Peachtree Road, N.E., Atlanta, Georgia 30309.
As for right now this is all of the completed information that I can give you. After final revision of our system, I hope that I can be of more help. I might mention that, since we are in a restructuring process, it would be greatly appreciated if you could share your findings from other facilities with us. We do have a great need in this area since we are a relatively young institution and are still in the process of building our staff development department.

If I can be of further help please let me know.

Sincerely,

[Signature]

Dennis W. Griffith
Director
Dear Mr. Elsberry:

Our training program for attendant personnel is in a developing stage at present. I have also been searching for training aids and have found very little in present literature. Several others have contacted me conducting the same sort of search.

All new staff receives a two hour basic orientation covering hospital rules and regulations and a hospital tour. Orientation then continues on the ward with experienced charge aides serving as trainers. Check lists are used to document each phase of the training.

Inservice classes are held weekly for a nine month period covering various aspects of care. Some of the topics covered this year were: Causes of Retardation, Epilepsy (a mouth long program), Behavior Modification, Job Instructions - training skills for the trainers, Management Skills for Supervisors, and a Goal Planning Workshop.

Due to a terrific turnover caused by pipeline impact, the orientation plans will change somewhat. In the future the staff development office will conduct weekly orientation classes in a ward classroom setting to supplement the job instruction training, while Inservice programs will be primarily aimed at developing supervisory skills.

We would appreciate any help that you can give us as you develop a state program of training your personnel.

Sincerely,

Constance Lehfeldt
Staff Development
Harborview Developmental Center
Dear Dr. Niesen:

I have been asked to respond to your request for in-service training material for direct care personnel. As a result, I am providing you with a copy of the MR-DUS Core Curriculum. The Core Curriculum outlines the basic in-service training provided at each of our five residential facilities. Although the material is primarily designed for training direct care personnel, Mental Retardation Aides and Nursing Aides, many sections can be utilized for all employees regardless of their job classification.

The Core Curriculum is divided into three phases. Phase I, Part I consists of 40 hours of in-service training provided for all new employees. In addition to Part I, direct care personnel receive Phase I, Part II which consists of 20 additional hours of training. All direct care personnel and other selected personnel, after six months of employment, are scheduled for Phase II of the Core Curriculum. Phase II includes 100 hours of training on a variety of topics. After 18 months of employment, all direct care personnel receive 80 hours of in-service training as set forth in Phase III. It is during Phase III that the employee is exposed to training in the area of supervision and management. Since you specifically requested information on this topic, I am sending you all of the reference material used during the Principles of Supervision/Management portion of Phase III.

Enclosed with this letter, you will find a copy of the table of contents for the entire Core Curriculum. However, due to the bulk and weight of the curriculum and other mentioned material, I am sending them under separate cover. You should receive these materials within a few days.
Dr. Niesen, Commissioner
October 14, 1975
Page Two

Please let me know if I can provide you with any additional
information. I will be more than glad to help in any way that I can.

Best of luck with your new in-service training program.

Sincerely,

Mark Hinterthuer
Acting Coordinator
MR-DOE Staff Development

Enclosure

cc: Mr. Charles E. Acuff
Mr. Michael J. Elsberry  
Assistant to the Commissioner  
Division of Mental Retardation and  
Developmental Disabilities  
2929 Kenny Road, Room B-105  
Columbus, Ohio 43221

Dear Mr. Elsberry:

I have been asked to reply directly to Doctor Niesen's letter to Mr. Allan Toedter of May 3, 1976 requesting information regarding direct-care personnel.

Enclosed for your information are job specifications for the classes of:

- Psychiatric Technician  
- Registered Nurse  
- Hospital Worker  
- Developmental Specialist

These specification sheets contain all the information requested by Doctor Niesen. If you have need of anything further, please feel free to contact me.

Sincerely,

[Signature]

Don Rowling, Chief  
Developmental Disabilities  
Hospital Services Section

Enclosures
September 15, 1975

Dr. Norman J. Niesen
Commissioner
Division of Mental Retardation
and Developmental Disabilities
2929 Kenny Road, Room B105
Columbus, Ohio 43221

Dear Dr. Niesen:

It was requested by the Director of the Division that I respond to your letter of September 5, 1975.

I am enclosing the instructional packages that we have available and information on how to order the others.

Thank you for your interest.

Cordially,

[signature]

Herb Fedrosvsky, Ph.D.
Coordinator Inservice Training

HP/In

enclosures: Assaying Student Behavior
Program Design
Fearon Flyer
ERIC Abstract
October 14, 1975

Dr. Norman J. Nieson, Commissioner
Division of Mental Retardation and
Developmental Disabilities
2929 Kenny Road, Room 3105
Columbus, Ohio 43221

Dear Dr. Nieson:

Your letter of October 6, 1975, has been referred to me for reply. I am enclosing an outline for our inservice training program, which also includes references for textbooks, films, etc. Many of our supervisory staff also contribute to this program by lecture. The inservice instructor then follows through and reinforces the materials presented. The instruction materials have not been developed into a packet, but I hope the outline will be of help.

We purchased a comprehensive training program from the Division of Mental Retardation and Developmental Disabilities, New York City, for use in our training of two of our staff to be trained as instructors. We have also had several of our staff attend business and management courses given by the University of Delaware and the Delaware Hospital Association. Several staff members have completed University courses and attended seminars in labor-management relations and are members of the bargaining team for the institution.

As you can see we have not had a crash program in inservice training for ward personnel or supervisory personnel. These programs have been in practice for many years and we are continually upgrading and adding relevant materials and sessions. I hope this will be of some help to you.

Sincerely yours,

[Signature]

James E. Weber
Director of Nursing

Enclosure

cc: Mr. Cohrt
    N. C. Putt
September 30, 1975

Dr. Norman J. Niesen  
Commissioner  
Division of Mental Retardation/and Developmental Disabilities  
2929 Kenny Road, Room B-105  
Columbus, Ohio 43221

Dear Dr. Niesen:

We are enclosing some of our staff development materials, as requested. From the tone of your letter, I am interpreting that you are in the process of reorganizing and redirecting your staff development program. Under the Florida Bill of Rights program, we have allocated funds to add forty additional staff development positions. Our plans are to establish two Retardation Staff Development and Training Institutes and four Satellite Staff Development Centers in selected areas of the state in order to build a network of staff training centers to more adequately meet the training needs of community and residential center personnel. Thus, we are in the early stages of a complete reorganization and redirection of our staff development program and look forward with enthusiasm to future developments in this area.

The Institute staff will concentrate on the development of training curriculum, instructional materials and teaching aids, etc., and will provide training to other staff development personnel in the curriculum developed. We are also establishing model training units which we will call Practicum, Observation and Demonstration Sites (PODS Program) for the purpose of pre-service and in-service training programs. This approach will relieve, somewhat, the problem of releasing staff for training, since new staff will be assigned to the specialized staff-client training PODS and will receive their training within the unit. They will receive an orientation and brief classroom training program before placement in the PODS, but once placed, much of the training will be provided by an experienced and well trained cadre of staff responsible for the skill and proficiency training needed, as well, to develop positive attitudes for habilitation and training of our clients.

Since we are in the beginning stages of our redevelopment process, we ask that you give us at least six months and then communicate with us about progress made.
Once we have established the Institutes, we plan to completely revise our curriculum; this will be based around a competency based mode. At that point, we will be in a better position to share experiences and training materials with you.

If we can be of further assistance, please contact.

Sincerely,

Francis P. Kelley
Director

Enclosures: Cottage Parent In-service Training Manual for Region II-A
Fox Techniques on Toilet Training - Region II-A
Resident Training Instructor In-service Training Manual
Project HIP-SHAPE Training Manual

cc: Mr. Robert Eaton
Mr. Ray Sutherland
December 11, 1975

Norman J. Niesen, Ed.D., Commissioner
Division of Mental Retardation and Developmental Disabilities
Ohio Department of Mental Health and Mental Retardation
2929 Kenny Road - Room B105
Columbus, Ohio 43221

Dear Dr. Niesen:

Your letter of October 6, 1975 was referred to me for handling.

Enclosed are some training materials that you may find helpful. These materials were developed by the Georgia Retardation Center In-Service Training Department and include:

1. Orientation
2. Basic training for attendant level staff
3. Human Sexuality and the Retarded
4. Basic unarmed self defense for dealing with aggressive-combative students
5. Supervision training
6. Dying, Death and Grief Seminar
7. Self Help Skills Manual

The Self Help Skills Manual and the Employee Handbook (not enclosed) are being revised now.

The Georgia Retardation Center In-Service Training Department conducts a basic supervision course for first line supervisors who need content that is more basic and simple than the Management in State Government Level I Course offered by the Merit System Training Division. Other supervisors are scheduled as needed to attend the Management Series Level I through Level IV presented by the Merit System Training Division.

I would like to share with you another project that the Georgia Retardation Center is implementing to improve...
their staff development program. On January 7, 1975, Dr. James D. Clements, Director of CRC, approved a Proposal For a Staff Development System, submitted to him by the Manpower Development Section of CRC. This systematic approach to building staff development activities was approved because it offered a logical decision-making structure and a process to enable management and manpower development to make choices which will achieve training and development goals efficiently and effectively. The proposed comprehensive staff development system is capable of developing training strategies based on training and educational continua for a broad spectrum of jobs. The system also relates to these functions:

1. recruitment, selection;
2. job design, task clusters, and hierarchies among jobs;
3. design of career structures to expand opportunities for employees to move horizontally and vertically through the system; and
4. development of a long range plan to gain accreditation of or credentialize training provided to Center employees by negotiating with community colleges and university allied health and continuing education departments.

CRC has begun the first step in designing a comprehensive staff development system. Effective June 9, 1975 a Task Force composed of Manpower Development and Personnel staff was trained to analyze jobs objectively, in order to generate tasks and training content necessary to yield the skills and knowledge required to perform a given job. The Task Force are utilizing the technology, Functional Job Analysis, developed and set in a systems planning context by Dr. Sidney Fine. FJA is both a conceptual and practical approach to defining jobs and how people function in relation to them. FJA focuses on task, rather than job as the fundamental unit of work and continually relates tasks to performance standards; and training content and applies various measures to tasks. Each task statement includes a description of the activities involved in the task, expected results, performance standards, training content, and measures of complexity, orientation prescription-discretion and general educational development, all relating to the requirements of the particular task. (see attached task statement). This information can be used to assess the complexity of the level of the tasks, infer worker qualifications, determine classroom and on-the-job training requirements, give
clear, accurate instructions to workers and develop criteria for assessing satisfactory performance. In this way all parts of the organization concerned with manpower—supervisors and administrators, trainers, program planners, recruitment and selected personnel, wage and salary specialists, etc., can work from a common understanding.

The Task Force has mastered the technology and are developing a Task Bank which is comprehensive for the Nutrition Service, a defined area of work. There are many applications that can be made from FJA data. But the Task Force's initial application of FJA data will be in the area of training and curriculum development.

I hope that you will derive some benefit from the enclosed information.

Sincerely,

Ralph A. McCain,
State Coordinator for
Staff Development
Developmental Services Section

Enclosure
Dear Mr. Niesen,

Thank you very much for your letter of October 6. We are still in the process of developing inservice training programs so I have no information available for you at this time.

I shall be glad to send you any information in the future as we develop our program.

Sincerely yours,

[Signature]

L. I. Wang
Planner

P. 0. Box 3373
Honolulu, Hawaii 96801

STATE PLANNING AND ADVISORY COUNCIL ON DEVELOPMENTAL DISABILITIES

P. O. Box 3378
Honolulu, Hawaii 96801

October 20, 1975

COUNCIL:
Leland K. Wai, Chairman
Joseph P. Cotta, Vice-Chairman

STAFF:
L. I. Wang, Planner

Norman J. Niesen, Ed. D
Commissioner
Ohio Department of Mental Health and Mental Retardation
2929 Kenny Road, Room B105
Columbus, Ohio 43221
Mr. Norman J. Niesen, Ed. D.
Commissioner
Division of Mental Retardation
and Developmental Disabilities
2929 Kenny Road, Room B 105
Columbus, Ohio 43221

Dear Mr. Niesen:

Idaho State School and Hospital is a 477 bed institution for
the mentally retarded. At ISS&H we have what I consider to be a very
comprehensive staff development program for our employees. I will out­
line briefly the kinds of in-service training we have on-going at the
hospital for our direct care personnel, and list resources which you
might find helpful in developing a staff training program for Ohio
institutional personnel.

Since June, 1974, we have made great gains in providing in­
service education to our employees. Since there had been very little
training in the last five years, we decided to begin with a general
forty hour orientation as a foundation for future programs. (I have
enclosed a topic outline of courses offered.) After all employees
completed the initial course, we began to develop and implement more
advanced courses for the ward personnel, specifically in the area of
behavior modification. We implemented staff B-Mod training in March,
1975 and to date have trained approximately 1/3 of our entire staff
in techniques of the operant conditioning approach to teaching mentally
retarded individuals. Our main resource for this program has been
Behavior Modification Technology, Inc. who designed a complete package
for in-service education including an administrative management and
staff training system along with a series of client treatment programs.
One or two institutions in Ohio are already using this program. At
ISS&H, we have also used resource material from Teaching Research in
implementing staff training. Every resident now has an individual
treatment plan and many are in one-to-one training sessions daily with
the direct care staff.
I am also conducting pre-service orientation for new employees. These employees receive a forty hour orientation, behavior modification classes, and on-the-job training for one month. In addition to these staff development activities, we offer films, lectures, and demonstrations which we feel are beneficial to employee training.

Regarding supervisory training, I am using a multi-module package written in behavioral objective form, which was developed by the Interagency Child Welfare Training Project at Idaho State University in cooperation with the Idaho Department of Health and Welfare. I suggest that you contact them regarding their supervisory package.

Probably the most significant staff training program at ISS&H is a Handicapped Teacher Education Special Project titled Project for the Care and Training of the Handicapped, funded by the Bureau of Education for the Handicapped. The purpose of the project is to prepare paraprofessional individuals to provide services to severely, profoundly and multiply handicapped persons.

To meet the objectives of the grant, twenty-five paraprofessional child care workers from Idaho State School, Region III and Region IV were enrolled at Boise State University on September 29, 1975 and are currently being trained in cooperative efforts by ISS&H and BSU. A major objective of the project is to develop a model curriculum for paraprofessional preparation to serve profoundly, severely, and multiply handicapped students. It is hoped that the project will also provide the institution with the expertise needed to develop a staff training program which would lead to the improvement of programs provided to the residents of this institution. It would also fulfill the obligation that ISS&H has to provide an adequate in-service training program as mandated in the Intermediate Care Facility regulations. With the additional funding, we hope to enroll twenty-five more DHW employees at BSU, while the initial participants begin their second year of coursework in paraprofessional training. We will continue to coordinate jointly with the Special Education Branch of the State Department of Education, Boise State University and centers for educating severely, profoundly and multiply handicapped formulative efforts to implement an Associate Degree Program for child care workers.

To my knowledge, there are no other training programs of this type in this and other Intermountain States. Regarding the curriculum development, we are only in the first semester of school, so most of the curriculum is still in the developmental stage. It is hoped that the curricula resulting from project efforts will serve as a standard of child care training nationally, as well as in the Intermountain States. Please contact me at a later date if you are interested in receiving further information on this project.
Suggested resources for in-service training programs:

1. Behavior Modification
      P. O. Box 597
      Libertyville, Illinois 60048
   b. Teaching Research, Inc.
      Monmouth, Oregon 97361

2. Supervisory Training
   a. Interagency Child Welfare Training Project
      Dr. Ruth Lovald, Coordinator
      (Ass't Professor of Sociology)
      Idaho State University
      Pocatello, Idaho
   b. Seattle Regional Training Center
      Civil Service Commission
      Federal Building
      Seattle, Washington 98174

3. B.E.H. Special Project and General Staff Development
   Barbara Lohmeier, Coordinator of Staff Development
   Idaho State School and Hospital
   P. O. Box 47
   Nampa, Idaho 83651

Please contact me if I can be of further assistance to you in your endeavors to provide in-service training for personnel working in institutional wards.

Sincerely,

Barbara Lohmeier
Coordinator of Staff Development

BL:sr
October 16, 1975

Norman J. Niesen, Ed.D.
Commissioner
Ohio Department of Mental Health
and Mental Retardation
Division of Mental Retardation
and Developmental Disabilities
2929 Kenny Road
Room B105
Columbus, Ohio 43221

Dear Doctor Niesen:

This is in reply to your letter of October 6, 1975, to Dr. Blanton,
Deputy Director for Developmental Disabilities, Springfield, Illinois. The Department utilizes a training committee for the purpose of developing training programs for Department of Mental Health personnel. For this reason I am referring your letter to Mr. Morten Knopf, Chairman, Department of Mental Health and Developmental Disabilities Training Committee, Administrative Office, 1601 East Taylor, Chicago, Illinois 60612. I am asking Mr. Knopf to reply directly to you regarding your concerns.

Very truly yours,

Stanley J. Pipp
Planning Specialist
Division of Developmental Disabilities

SJP; kjd
Dr. Norman J. Niesen, Commissioner
Division of Mental Retardation and
Developmental Disabilities
2929 Kenny Road/Room B105
Columbus, OH 43221

Dear Dr. Niesen:

Your letter of October 6, 1975, to Mr. Dennis Popp has been referred to me for response. Kansas Law now requires that personnel working in institutional residential settings must be licensed as Mental Health Technicians. Enclosed is a copy of the regulations for accrediting training programs as issued by the Kansas State Board of Nursing.

Also enclosed you will find a description of the training programs that we conduct at Kansas Neurological Institute. You will note that we have designed a curriculum which leads to: (1) Certification by the State Board of Nursing; and (2) An Associate Degree in Human Development Technology. In short the achievement of certification leads to employment as a Mental Health Technician in the Residential setting, i.e. your "ward personnel" and the associate degree qualifies the individual for appointment to supervisory status.

If I may be of further assistance do not hesitate to call on me.

Sincerely,

Roy W. Rutherford, Ed.D.
Coordinator of Training and Career Development

Enclosures

cc: Mr. Dennis Popp, Coord. Dev. Dis.
Dear Dr. Niesen:

I have been asked by Mr. Estes to respond to your letter of September 5.

In-service training in Louisiana is divided into two nonoverlapping components: state-wide in-service training and facility (institution)-wide in-service training. The state-wide in-service training program is administered at the state office and is responsible for all interfacility training and coordination. Facility-wide in-service training programs are conducted by each facility and are responsible for all in-service training and coordination within individual facilities.

I have enclosed a copy of our state-wide in-service training manual (the MR SEED program) and also a copy of one of our facility-wide in-service training manuals, that is used by Pinecrest State School at Pineville, Louisiana. I hope these will be of some use to you. If I can be of any further help, please let me know.

Sincerely,

Donnell C. Ashford
Supervisor of In-Service Training and Psychological Services

DCA/td
Enclosures
October 8, 1976

Norman Niesen, Ed.D.,
Commissioner
Division of Mental Retardation
and Developmental Disabilities
2929 Kenny Road
Columbus, Ohio 43221

Dear Dr. Niesen:

We are in receipt of your letter of October 6, in which you requested information pertinent to training programs for institutional staff. I am forwarding your letter to the Superintendents of Finland Center and Elizabeth Levinson Center in Maine, which are two state operated mental retardation facilities.

I am sure they will be in touch with you regarding the training information.

If we can be of other assistance please contact us.

Yours truly

Kevin C. Baack
Assistant Director
Bureau of Mental Retardation

Encl.
cc. Richard Lepore
cc. George Zitnay
October 22, 1975

Norman Niesen, Ed.D.
Division of Mental Retardation and Developmental Disabilities
2929 Kenny Rd.
Columbus, Ohio 43221

Dear Dr. Niesen;

At the present time we do not have a complete training package for staff in either direct care or first line supervisory positions. After three years of limping along by the seat of our pants, we are hoping to pull together a comprehensive inservice plan by early next year, but right now we're still in the talking stages.

Sincerely,

Paul N. Tabor
Director of Staff Development
June 1, 1976

Mr. Michael J. Elsberry
Assistant to the Commissioner
Ohio Department of Mental Health
and Mental Retardation
2929 Kenny Road
Room B105
Columbus, Ohio 43221

Dear Mr. Elsberry:

Mr. Monaghan has turned over to me your letter of May 7. I will gather together some information and examples of our training programs involving the direct-care attendant and will send these to you under separate cover.

I did not see the original letter (November 1975) from Dr. Niesen and would appreciate any information about your program which may be helpful to our training programs.

Sincerely,

[Signature]

Dr. Eveline D. Schulman
Director, Evaluation, Training
and Resources

EDS/dcp
Norman J. Niesen, Ed.D.
Commissioner
Division of Mental Retardation and Developmental Disabilities
2929 Kenny Road
Room 8105
Columbus, Ohio 43221

Dear Dr. Niesen:

Dr. Robert Okin has asked me to respond to your letter dated October 6, 1975. I share your concern for inservice training of ward personnel and supervisory candidates. I have only in the last few weeks been assigned the responsibilities to develop just such programs and regret that I have no training packages to share with you.

We have developed a variety of manuals, guides, films and slide tapes and they are now available through a private non-profit foundation. You will find a list of some of the material enclosed.

If you get any replies from other states, I would very much appreciate a list of those states who have such packages, so that I may contact them to also learn about them. We are working on some proposals for which intend to very much depend on existing materials rather than everybody starting from scratch, so we will share what we have and hope you will do the same.

Sincerely,

Levis B. Klebanoff, Ph.D., S.M. P.G.
Assistant Commissioner for Mental Retardation

LBK:nh
CC: Dr. Hoffman
Dr. Okin
Mr. Norman J. Niesen, Ed. D.
Commissioner
Ohio Department of Mental Health
And Mental Retardation
2929 Kenny Road, Room 8105
Columbus, Ohio 43221

Dear Mr. Niesen:

This is to acknowledge receipt of your letter of October 6 requesting a copy of the in-service training programs for personnel working in our State institutions.

The specific material that you request is in the final stages of preparation. Hopefully, these materials will be ready for dissemination in about two weeks. I will forward to you at that time the completed attendant in-service training materials.

Sincerely,

Miss Evelyn Provitt, R.N.
Associate Administrator
Treatment and Normalization System
October 8, 1975

Dr. Norman Niesen, Commissioner
Division of Mental Retardation
2929 Kenny Road, B-105
Columbus, Ohio 43215

Dear Norm:

Over the past three years, the Macomb-Oakland Regional Center has focused on the development of community residential programs. Our experience in this endeavor has led to a change in training emphasis. Rather than viewing the mentally handicapped institutional resident as the primary target of education prior to placement, direct care personnel within each community residence, are seen as equally important recipients of training.

The intent of the enclosed manual, Resident Manager Training, is both to present a rationale for our emphasis on resident manager education and to share a functional curriculum we have developed to address this education.

The manual, developed by Gerald Provencal, Director of Programs, and David Evans, Grant Coordinator, is being sent to you as part of a very limited edition. It is hoped that you will critique the work and communicate your impressions to us. After all reviews are completed, a second and improved, edition will be printed. This edition will appear in a more finished fashion and be available before the first of the year. Any detailed reading and critique will, of course, be acknowledged within the volume.

We hope you find the material interesting as well as useful. Your reactions will be appreciated.

Sincerely,

David Rosen
Director

[Signature]
November 6, 1975

Norman J. Niesen
Division of Mental Retardation
and Developmental Disabilities
2929 Kenny Road, Room 6105
Columbus, Ohio 43221

Dear Dr. Niesen:

After going through the hands of three other persons, your letter regarding the new requirements for in-service training in Ohio came to my attention. The rationale, I am sure, is that 1) I serve as a consultant to the Training Coordinators in our state institutions and 2) I am currently the instructor for two of our supervisory training courses and will start a third after the first of the year. We are working under some state mandates and can empathize with your position.

Under separate cover, I am sending several items which may be of help to you. The first, and perhaps most important, is the Department Training and Development Plan which we are required to submit to the Commissioner of Personnel. To elaborate on our implementation of the Plan, I am enclosing the pages from our Activity Book. These are loose leaf and can be updated on a regular basis.

In July, Minnesota entered upon a new four-step career ladder for human services personnel (paraprofessionals). We are doing much groping as we move toward establishing the training requirements. Most of us in the staff development field, both in the institutions and in the Central Office of Welfare, are committed to a competency-based approach. Unfortunately, we find ourselves in the middle of the process, working both ways. That is not easy!

A tool we are finding helpful in establishing all our training needs (including those on the career ladder) is the Minnesota Employee Performance Appraisal System. This plan uses the annual evaluation of the employee as a means to develop his/her individual training program. The approach is to provide training to 1) close any gap between performance and job requirement and 2) provide means for the employee to grow on the job. With the packet of materials, I am sending the Supervisor's Manual which explains the program. (If you wish further information, you might contact Richard Cottrell, Minnesota Department of Personnel, Room 712, MIA Building, St. Paul, Minnesota 55155.)

Please feel free to request elaboration on any of these matters if we can be of further help.

Sincerely yours,

Alice Huston
Staff Development Consultant
Dear Mr. Elsberry:

Dr. Paul Cotton, Director of the Division of Mental Retardation, State Department of Mental Health, has asked me to respond to the request of Dr. Niesen for information concerning direct-care personnel in our state. I hope the following information will be useful to you.

Attached to this letter is a Compensation Table for the State of Mississippi. Our state does not have a Civil Service. It operates instead under a State Classification Commission which establishes all pay groups. The Compensation Plan lists all classified job slots classified by the Commission for the State Department of Mental Health. I have included a Compensation Plan for your information. If a particular job title is not listed in this Plan, then the salary is established by law.

Direct care attendant personnel in the Division of Mental Retardation are placed in four categories. Lowest of the four is the cottage attendant. This is a minimum wage position which changes only if the person is promoted to cottage parent or works the night shift and is paid a shift differential. Cottage attendants are supervised by cottage life parents I, II, or III, depending on the shift and work location.

Attendents are generally unskilled and require extensive training in working with the mentally retarded. Responsibilities of cottage attendants include helping in the care, training, supervision, and guidance of residents. Attendents have responsibilities for housekeeping and food handling. They are involved in the planning and review of residents' programs and may have contact with parents through staffing sessions.

The other three categories of attendant personnel are classified with written job descriptions attached. The Supervisor of Residential Services is basically a shift supervisor with extensive responsibility, especially between the hours of 4:30 P.M. and 8:00 A.M.
It should be pointed out that we look on other staff members as direct care staff in addition to attendants. We feel that any person who works directly with residents fits into the direct care category. This includes teachers, recreators, nurses, and some psychology and social work jobs. If you need job descriptions and pay scales for these personnel, please contact me.

Good luck in your efforts.

Sincerely,

Larry E. Grantham, Ph.D.
State Coordinator
University Affiliated Program

Enclosures - 5
October 10, 1975

Norman J. Niesen, Ed.D.
Commissioner
Ohio Department of Mental Health
and Mental Retardation
2929 Kenny Road
Room B105
Columbus, Ohio 43221

Dear Dr. Niesen:

In accordance with your letter dated October 6, 1975, addressed to Dr. Arnold Carmel, we are providing you with a set of the training booklets that are used in our in-service training program at the Beatrice State Home. This material has been provided by Mr. M. E. Wyant who is Superintendent of the facility. For your further information, we are enclosing copies of the Classification Specifications which will indicate to you the line of progression from entry on duty as a Human Resources Candidate. The salary ranges are also provided as typed at the top of each form.

In that the material provided you is somewhat excessive, it is being mailed to you "under separate cover" as printed material.

I trust that this will provide you with the information requested; and in the event you would like additional information or clarification on this material, I suggest you direct your communication to Mr. M. E. Wyant, Superintendent, Beatrice State Home, Box 808, Beatrice, NE 68310.

Yours very truly,

C. F. Weidenthaler
Personnel Director

Copy: Superintendent, HSH

Enclosures: Under separate cover

Attachments
May 20, 1976

Michael J. Elsberry
Assistant to the Commissioner
Division of Mental Retardation
and Developmental Disabilities
2929 Kenny Road
Room R105
Columbus, Ohio 43221

Dear Mr. Elsberry:

May I apologize for the delay in answering Dr. Niesen's request for material regarding attendant personnel training material. Apparently the request was not directed to my office at that time.

I have enclosed the broad basic outlines used in our in-service training program. These, of course, are modified to meet the needs of our individual facilities and are used as general guides.

Training is provided by LPN's and/or RN's as the subject requires.

If the material included is too general, please advise me, and we will directly contact our instructors for additional information.

Again, my sincere apology for the delay.

Sincerely,

JAYNE BAKER
Personnel Administrator

Enclosures
November 5, 1975

Norman J. Niesen, Ed.D.
Commissioner
Ohio Department of Mental Health
and Mental Retardation
2929 Kenney Road
Room E105
Columbus, Ohio 43221

Dear Mr. Niesen:

Enclosed are materials requested regarding personnel working with institutional residents.

If additional information or assistance is needed, do not hesitate to let us know.

Sincerely yours,

Sandra Grissom
DDSA Administrator
Mental Retardation Services

SG:1bg

Enclosures

cc: Ann Wolfe
    Mike Hennike
October 29, 1975

Norman J. Niesen, Ed.D.
Commissioner
Division of Mental Retardation
and Developmental Disabilities
2929 Kenny Road, Room B105
Columbus, Ohio 43221

Dear Dr. Niesen:

I have been asked to respond to your requests for materials related to the training of ward personnel. Our experience with program development along similar lines, and for similar purposes, gives us a sense of appreciation of your need.

The Department's Bureau of Education and Training has mandated an orientation program for all new employees which embraces areas of minimal knowledge and skill for functioning within a setting for the care of the mentally disabled. I am enclosing a copy of the mandated syllabus so that you may learn where the focus lies in our orientation sessions. All of our facilities are expected to teach to the minimums described but we find that, in many places, the education units of psychiatric and developmental centers go beyond these minimums in content presentation and development.

The Department of Mental Hygiene has also developed a training package to instruct employees in the essentials of supervision. The material is currently under revision but should be ready within 2-3 weeks for distribution and implementation. I shall be pleased to forward a set of the revised syllabus and course outline at that time.

If there are other ways in which we may be of assistance, please let me know.

Sincerely yours,

FRANK TOSIELLO, R.N., Ed.D.
Deputy Director
Nursing Education and Training

cc: Dr. Ornstein
Dr. Wexler
Mr. Schwadron
May 17, 1976

Michael L. Elsberry
Assistant to the Commissioner
Division of Mental Retardation and Developmental Disabilities
2929 Kenny Road/Room B105
Columbus, Ohio 43221

Dear Sir:

This is in regards to your follow-up letter dated May 7, 1976. I would like to direct you to Mr. Paul Witucki, Assistant Superintendent for Grafton State School, Grafton, North Dakota. Mr. Witucki is in charge of all programs at the institution and would be able to answer any questions on training programs for attendants.

Sincerely yours,

Carl D. Rodlund
Director
Community Mental Retardation Programs

CDR: cks
State of New Hampshire
DIVISION OF MENTAL HEALTH
CENTRAL OFFICE
105 PLEASANT STREET
CONCORD 03301

May 25, 1976

Mr. Michael J. Elsberry
Assistant to the Commissioner
OHIO DEPT. OF MENTAL HEALTH & MENTAL RETARDATION
2929 Kenny Road
Room B105
Columbus, Ohio 43221

Dear Mr. Elsberry:

Your request for information was forwarded to me. My office (and thus a centralized, statewide focus on training/education) is only nine months old. No state plan of the nature which I think you are looking for is available. I will, however, try to piece some information that should be of help to you.

First, please find attached, a copy of our training objectives for personnel in our services to persons with Developmental Disabilities system. These objectives represent our first attempt to centralize training objectives consistent with management objectives (i.e. service deliver/objectives).

Second, I have forwarded a copy of your letter to Dr. Frances Cooke, Director of In-Service Training at the Laconia State School and Training Center. Dr. Cooke is also new to our system, but may be able to forward you some materials on specific training plans. The Laconia State School and Training Center is our only residential facility for the Developmentally Disabled.

I hope the above is of help to you. We will send additional material as it is developed. Please send us anything you might develop, also -- we are all in the same "boat".

Sincerely,

Ronald C. Andrews, Director
Training and (Manpower) Development

RECEIVED
MAY 27 1976

DIVISION OF MENTAL RETENTION & DEVELOPMENTAL DISABILITIES
State Director of Training for MR

c/o Dr. Norman Niesen
Commissioner
Division of Mental Retardation
State Office Bldg., 12th FL
65 South Front St.
Columbus, OH 43215

Dear Sir:

I am writing to acquaint you with a training program which we have found helpful in Pennsylvania in our work with developmentally disabled persons. This program is entitled "Goal Planning: Procedures for Developing Individualized Client Plans." It was developed by The Pennsylvania State University under contracts from The Pennsylvania Office of Mental Retardation and grants from The Social and Rehabilitation Service. The program is intended for front-line staff who work directly with clients (e.g. aides, professional staff, volunteers, parents, etc.) and shows them how to develop individualized client plans with the following features:

1) The client is maximally involved.
2) Focus is on the client's strengths and how to use strengths to help with his needs.
3) Small steps are used to achieve the goals.
4) The method is clearly stated including behavioral objectives, staff responsibilities and target dates.

As you know, individual program plans with clearly stated program objectives are required for federal funding of skilled nursing and intermediate-care facilities, for funding under the Rehabilitation Act of 1973 and for JCAH accreditation of MR residential facilities and community agencies. For these purposes we have used the program extensively in Pennsylvania, both in institutions and in community agencies. Over 1,000 persons have been trained to date in our state and several other states also have begun to use the materials. We have been pleased with the response and would like to inform others of the availability of this technique. Since the program was developed with public funds, the training materials may be reproduced provided they are not altered or sold for profit.

We are planning a conference in Hershey, Pennsylvania on October 28 and 29 to explain the Goal Planning Program, to demonstrate its uses and to answer questions which people may have about it. The
September 19, 1975

schedule for this meeting is enclosed. Participants must provide their own travel and per diem expenses, but all other expenses will be defrayed by the project including a complete set of the training materials for each participant to keep.

All interested persons working in the field of developmental disability are welcome to attend. However, registrations must be received by October 17 in order to have appropriate space available. If you have any further questions, please contact Dr. Peter Houts, Department of Behavioral Science, The Milton S. Hershey Medical Center, The Pennsylvania State University, College of Medicine, Hershey, Pennsylvania 17033 (Phone 717+534-8265).

I hope that you and others from your staff can join us.

Sincerely,

Stanley Moyers
Deputy Secretary
for Mental Retardation

Enclosures:
1) Goal Planning with Developmentally Disabled Persons Workbook.
2) Evaluating Individualized Goal Plans Workbook.
May 18, 1976

Gentlemen:

We are in the process of developing a State Adventure & Learning Park for the handicapped and non-handicapped people. The park will be a vital step forward in implementing a total normalization effort in behalf of the handicapped. We would appreciate any information that you might have in the areas of play apparatus, nature trails, park and playground design that could assist us in this future development.

As soon as our plans are finalized and the park is developed, we will mail you a brochure if you so indicate. Please mail the above information to Mr. Owen W. Dean, Director of Parks & Recreation, Utah State Training School, American Fork, Utah, 84003.

Sincerely,

Paul S. Sagers, Ed.D.
Superintendent

Owen W. Dean
Director of Parks & Recreation

UTAH STATE TRAINING SCHOOL
AMERICAN FORK, UTAH 84003

PAUL S. SAGERS, Superintendent
October 10, 1975

Norman J. Niesen, Ed.D.
Commissioner, Division of Mental Retardation & Developmental Disabilities
Ohio Department of Mental Health & Mental Retardation
Room B 105
2929 Kenny Road
Columbus, Ohio 43221

Dear Dr. Niesen:

Your letter of October 6, 1975, which was addressed to Dr. Dan Payne, Assistant Commissioner for Mental Retardation in Virginia, has been forwarded to me.

The request for copies of training materials and programs for institutional ward personnel comes at a time when we, too, are beginning to develop appropriate standards and receive training requirements.

We are not able to make a positive response to your request at this time but look forward to the possibility of sharing information and plans as we both proceed in our efforts.

If the results of your search for information produce examples of programs you consider valuable, I would appreciate your sharing the name of the source with us.

We wish you success.

Sincerely,

Tom Risinger, Dr. P.H.
Director of Training & Staff Development

CC: Dr. Dan Payne
November 5, 1975

Norman J. Niesen, Ed.D
Commissioner
Ohio Department of Mental Health
and Mental Retardation
2929 Kenny Road
Room 8105
Columbus, Ohio, 43221

Dear Dr. Niesen:

Your request to Mr. Maurice Harron for information on our training of institutional personnel was forwarded to me by the superintendent of Fircrest School, Mr. Frank Junkin.

Enclosed please find copies of our In-Service Education Department policies and the goals and objectives of our five basic programs: Orientation to the School; Physical Care of Residents (Basic and Advanced); and Training of Residents (Basic and Advanced).

Appropriate department heads teach the Orientation Program. The Physical Care Program is taught by a registered nurse, and the Training of Residents Program taught by a psychologist.

Many additional programs are offered to increase staff skills in the care and training of Fircrest residents. Such programs are chosen as a result of a "need" survey, and are then taught by the appropriate disciplines.

Some supervisory personnel have taken courses in the principles of supervision through our local educational institutions or through the State Training Center. Additionally, we have offered courses at Fircrest on interpersonal relationships.

We do not, however, have a standard, mandated program for ward supervisory personnel, although we recognize the need. We are working towards that end at the present time.

I hope this information is of assistance.

Sincerely,

Frank E. Junkin
Superintendent

Edith M. Watson, R.N., M.N.
Coordinator, In-Service Ed.
Fircrest School
1580-15th Ave. N.E.
Seattle, Washington, 98155

Encl.

cc: Maurice Harron
  Frank Junkin
Norman J. Niesen, Ed.D., Commissioner
Division of Mental Retardation and
   Developmental Disabilities
Ohio Department of Mental Health and
   Mental Retardation
2929 Kenny Road, Room 8105
Columbus, Ohio 43221

Dear Dr. Niesen:

In reply to your letter of October 6, 1975, we are sorry
to inform you that we have no training package in either of the
areas you inquire about. However, we might suggest you contact
Ms. Libby Edge, Director, Home Life Program, Colin Anderson Center,
St. Marys, West Virginia, 26170, and Mr. Blaine Dowler, West Virginia
Department of Mental Health, State Capitol, Charleston, West Virginia,
25305, regarding this matter.

If we can be of help to you in any other matter, please do
not hesitate to call on us.

Sincerely,

(Ms.) Wanda N. Radcliffe
Coordinator of Training
Developmental Disabilities

KNR:pc
November 3, 1975

Dr. Norman J. Niesen, Commissioner
Division of Mental Retardation and Developmental Disabilities
2929 Kenny Road, Room B105
Columbus, OH 53221

Dear Dr. Niesen:

Mr. Dymond has asked me to respond to your recent request for training materials. These are being sent under separate cover.

This reply was delayed because some of these materials have just become available.

If you have further inquiries, please let me know.

Sincerely yours,

Robert J. Trobaugh, Ph.D.
Training Officer

RJTmap
Dear Dr. Niesen:

Am sorry to advise that we do not have the training material requested in your letter of October 6.

Sincerely,

WYOMING STATE TRAINING SCHOOL

Fred W. Hefyford, Ed.D.
Superintendent

FWH:ls
APPENDIX K:
Expert Panel's Evaluation of Ohio's Staff Development Program for the Mental Retardation Worker I
APPENDIX K

EXPERT PANELIST EVALUATION OF THE CONCEPTS OF MODULE I: FUNDAMENTALS OF MENTAL RETARDATION

### SUMMARY OF EXPERT PANEL EVALUATIONS

The number in each column indicates the number of responses for that particular concept.

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**I. WHAT IS MENTAL RETARDATION?**

1.1 Mental Retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period.

1.2 An individual who is mentally retarded must demonstrate deficits in both measured intelligence and adaptive behavior.

1.3 Adaptive behavior is the degree with which an individual meets the standards of personal independence and social responsibility expected of his/her cultural group.

1.4 The four progressive degrees of mental retardation are classified as profound, severe, moderate and mild.

1.5 Each category of mental retardation represents different levels of the development of skills necessary to carry out skills of daily living.

1.6 Mild retardation refers to individuals who are generally capable of social and vocational adequacy with the proper training.

1.7 Moderate retardation refers to those mentally retarded individuals, who are capable, after training, of self-maintenance in unskilled or semi-skilled occupation.
1.8 Severely retarded individuals require continuing
and close supervision but may perform many self-
help and some simple work tasks under supervision.

1.9 Profoundly retarded individuals require con-
tinuing and close supervision but some may be able
to perform simple tasks--these individuals many
times have other handicaps and require total life
support systems for maintenance.

II. CAUSES OF MENTAL RETARDATION

2.1 Mental Retardation can be acquired and/or in-
herited.

2.2 Mental Retardation, caused by developmental
difficulties during the months of pregnancy is
called a prenatal difficulty.

2.3 The most common cause of mental retardation during
the prenatal period is infections (i.e. influenza,
measles, syphilis, etc.).

2.4 Postnatal causes of mental retardation are in-
fecions; physical injuries to the head; and,
extremely high and uncontrolled fevers.

2.5 The most common causes of mental retardation
during birth (perinatal) are: difficult de-
liveries; prematurity; and, cord around the neck.

III. CONCEPTS IMPORTANT IN THE CARE AND TREATMENT OF THE
MENTALLY RETARDED

3.1 Adaptive behavior is defined as the effectiveness
or degree with which the individual meets the
standards of personal independence and social
responsibility expected of his/her cultural group.

3.2 Attendant is defined as a person employed to
provide supervision and guidance as well as
basic care and training services to the in-
dividual living within an institution.

3.3 Cerebral Palsy is a disorder dating from birth
or early infancy, which is usually non-progressive,
characterized by poor motor functioning
(palsy, tremors, contractions, etc.) and
other problems in thinking, perception, lan-
guage, learning and behavioral disorder.
3.4 Legal commitment is assignment to custody, confinement, or treatment—by Court Order.

3.5 Day Care Programming is defined as extended care services provided on an ongoing basis for mentally retarded individuals residing in a community setting.

3.6 Dependent mental retardation is defined as a mentally retarded individual who requires continued supervision or assistance in his/her social, academic, and daily living skills.

3.7 Evaluation is the appraisal of an individual by the application of techniques that show the physical, mental, social, economic, and intellectual resources of an individual and his/her family.

3.8 Habilitation programming is the process by which the staff of an institution assists the resident in acquiring and maintaining those life skills which enable him/her to cope more effectively with the demands of his/her own person and of his/her environment.

3.9 Independent functioning is the ability of an individual to accomplish successfully those tasks or activities demanded of him/her by the general community, both in terms of critical survival demands within the community and in terms of the typical expectations of specific age groups.

3.10 An institution is a public or private facility providing 24-hour professional services to the mentally retarded. These services include: care, treatment, habilitation and rehabilitation of the resident.

3.11 Providing for optimal training of residents in an environment as free of constraint as possible, within an institutional setting, is referred to as the concept of least restrictive environment.

3.12 Life support care is the care necessary for some profoundly retarded individuals with major biochemical problems i.e. requiring oxygen, special feeding, etc.
3.1.3 A term meaning that the mentally retarded individual has the same basic rights as any other human being is referred to as normalization.

3.1.4 Right to Treatment is the obligation of the State of Ohio to provide its residents with appropriate opportunities to develop physically, mentally, socially, and vocationally.

3.1.5 The organization of an institution into effective units, to better enhance both the education and training of the mentally retarded is unitization.

IV. INCIDENCE AND PREVALENCE OF MENTAL RETARDATION

4.1 There are approximately 6.0 million mentally retarded individuals in the United States.

4.2 Only 5% of all the mentally retarded reside in institutions.

4.3 Between 2 and 3% of the general population are thought to be mentally retarded.

4.4 It is thought that only 10-15% of the mentally retarded population fall into those categories of profound, severe, moderate, of which most find their way into the institutions.

V. COMMON FALLACIES IN MENTAL RETARDATION

5.1 Just because an individual is mentally retarded doesn't make him/her look abnormal.

5.2 Mental retardation is not a disease.

5.3 Mentally retarded individuals are not criminals.

5.4 Mentally retarded individuals can be trained like everyone else.

5.5 The mentally retarded have special needs just like everyone else.

5.6 Heredity is only one cause of mental retardation.
EXPERT PANELIST EVALUATION OF MODULE II: S.B. 336 (RIGHT TO TREATMENT)

I. INTRODUCTION TO S.B. 336

1.1 S.B. 336 is designed to insure that mentally retarded persons in the State of Ohio retain all rights as afforded other citizens.

1.2 As a direct-care worker (attendant) you will be most directly involved with (under 336) the promotion of human dignity of the mentally retarded.

1.3 As a direct-care worker you will be directly involved with the development of the ability and potential of the mentally retarded individual to the fullest possible extent.

1.4 As a direct-care worker you will be directly involved with the promotion of the economic security, standard of living, and meaningful employment of the mentally retarded.

1.5 As a direct-care worker you will be directly involved with the maximum assimilation of mentally retarded persons into the ordinary life of the communities.

1.6 As a direct-care worker you will be directly involved with the process of least restrictive environment.

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416
II. THE CIVIL RIGHTS OF RESIDENTS IN INSTITUTIONS

2.1 Persons hired to work with residents within institutions for the retarded, must be in agreement with the principals set forth in S.B. 336, and will conscientiously protect the rights of the clients.

2.2 An employee of the Division of Mental Retardation, who deliberately denies a client's civil rights will be subject to disciplinary action and may be liable to civil action.

2.3 All residents are allowed to receive visitors.

2.4 All residents are allowed reasonable access to telephones.

2.5 All residents are allowed reasonable access to writing materials and postage.

III. VOLUNTARY AND IN VOLUNTARY ADMISSIONS

3.1 Under S.B. 336 there are two types of admissions -- voluntary and involuntary.

3.2 Any non-institutionalized person, who may be mentally retarded, may apply for voluntary admission.

3.3 Voluntary admissions are only approved by the Division of Mental Retardation if it is in the best interest of the individual applying.

3.4 Involuntary admissions, under S.B. 336, must be made by the Court.

3.5 There are two classes of clients who may be admitted involuntarily to a State institution -- those who represent a substantial danger to themselves (because of inability to provide for basic needs) and those susceptible to significant habilitation in an institution.

3.6 Involuntary commitment can only take place when three conditions are present: (1) the client is moderate, severe or profoundly retarded; (2) the client represents a substantial danger to himself; and, (3) there is a lack of appropriate community resources to aid the individual.
IV. RESIDENT ABUSE/RESIDENT LABOR

4.1 Any direct-care worker who suspects a resident has been abused or neglected must file a written report which describes the client's condition; the nature of the injuries; and, the possible cause of the injuries.

4.2 S.B. 336 provides that any person reporting or testifying in an abuse case will have immunity from civil or criminal prosecution on matters surrounding the alleged incident.

4.3 A client may not perform labor for the support and maintenance of the facility without receiving wages in accordance with the Fair Labor Standard Act.

V. THE INDIVIDUAL HABILITATION PLAN (IHP)

5.1 The IHP is a plan which will assist a resident in their maximum social, emotional, and physical development.

5.2 The correct definition for an IHP is that it is a plan that will assist the resident in receiving maximum social; emotional; and, physical development.
EXPERT PANELIST EVALUATION OF MODULE III: HABILITATION PROGRAMMING FOR THE RETARDED (ITS IMPORTANCE AND PURPOSE)

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1. ALL LEARNING EXPERIENCES QUESTIONS COMBINED

1.1 Habilitation refers to the process by which the staff of an institution assists the resident in acquiring and maintaining those life skills which enable him to cope more effectively with the demands of his own person and of his social environment and allows him/her to raise the level of his/her physical, mental, social and vocational efficiency.

1.2 Programming refers to a systematic plan for eliminating maladaptive behavior and producing adaptive behavior.

1.3 Staff involved in making an IHP for a resident should spend a great deal of time in careful observation, interviewing, and general interaction with the resident.

1.4 An increase in behavior can be accomplished through reinforcement.

1.5 Systematic checking and observation of behavior following prescribed time periods is known as a time sampling procedure.

1.6 Using small steps to reach a certain kind of behavior is known as shaping.

1.7 Abilities to toilet, eat, dress and groom are known as basic self-help skills.

1.8 Habilitation programming can be utilized for normal as well as retarded individuals.

1.9 Habilitation refers to skills necessary for living.
1.1.0 A well-designed plan is necessary in order for proper habilitation to occur.

1.1.1 Teaching from an IHP should be measured in small steps.

1.1.2 It is important for results of a positive nature to follow a particular behavior.

1.1.3 Habilitation planning not only includes those behaviors associated with personal needs but also includes social and vocational behaviors.

1.1.4 A proper habilitation plan specifies behavioral objectives and means for attaining them.

1.1.5 Reinforcement refers to increases in frequency of behavior.

1.1.6 Shaping is a useful tool in teaching a complex series of behaviors.

1.1.7 Basic self-help skills are basic to performance of other activities in life.

1.1.8 Punishment is not a useful tool in dealing with human behavior.
EXPERT PANELIST EVALUATION OF MODULE IV: CARE TREATMENT AND SAFETY OF THE RESIDENT

I. CONCEPTS IN CARE TREATMENT AND SAFETY OF THE RESIDENT:

1.1 When drinking liquid from a cup the liquid is poured over the lower lip which moves it to the rear of the mouth for swallowing.

1.2 Eating problems occur when a resident has (1) a large tongue; (2) a lazy tongue; and, (3) a tongue thrust.

1.3 An attendant should allow the resident to chew his/her food slowly and let him swallow before giving him/her a second spoonful.

1.4 Dressing your residents each day is a step toward normalization.

1.5 Toilet training must be undertaken on a consistent basis.

1.6 Residents should never be punished for toilet training accidents.

1.7 Fingernails and toenails should be cut at least every two weeks, but a better method is to survey fingernails and toenails daily and cut them when needed.

1.8 Mouth care for residents should be done on a daily basis.

1.9 Two important things to remember when feeding a resident are: (1) keep the resident comfortable; and (2) keep the noise level quiet.

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1.1.0 When bathing a resident he/she deserves as much privacy as an attendant can provide him/her.

1.1.1 When planning leisure time activities, direct-care workers should include the residents' own ideas on what they would like to do.

1.1.2 The best position for eating is upright.

1.1.3 The mouth needs the same care when dentures are worn as it does with one's own teeth.

1.1.4 All infections are not caused by virus.

1.1.5 Cardiac arrest means the heart has stopped beating.

II. NURSING/MEDICAL TERMINOLOGY USED ON A UNIT

2.1 Body wastes discharged by the anus are called feces.

2.2 The lower part of the large intestine is the rectum.

2.3 The outlet of the rectum is called the anus.

2.4 Males sex glands are called testes.

2.5 Production of orgasm by self-manipulation is called masturbation.

2.6 Removal of the foreskin from the penis is called circumcision.

2.7 Female reproductive glands are called ovaries.

2.8 A canal which urine is discharged is called the urethra.

2.9 The periodic discharge of bloody fluid in a female is called menses.

III. BEHAVIORAL RESTRAINT: THE AGGRESSIVE RESIDENT

3.1 In the event of a resident becoming a danger to himself/herself, an attendant should (1) try to talk with the resident softly, and if necessary, sternly -- make him/her feel secure. Try to get him/her to stop on his/her own. If this fails then:
3.2 Gather several staff members (3 to 5) and subdue the resident. Hands and legs should be restrained. The Unit doctor should then be notified. In the event of headbanging, headgear should be employed.

3.3 Following restraint for "danger to self", efforts should be made by professional staff to calmly talk to the resident and soothe him.

3.4 Following 3.3 above, staff member should attempt to determine the reasons for the violent action by questioning the resident -- as well as those staff present at the time.

3.5 In the event of threatened danger to others, the direct-care worker should: (1) try to quiet the resident(s) first be talking calmly, and if necessary, sternly. If this fails then:

3.6 Enough staff should be gathered to safely restrain the residents. If more than one aide is involved staff from other cottages may be called in.

3.7 Staff should restrain the resident(s) from behind, preferably about the knees. Once restrained, the cottage physician should be notified.

3.8 Procedures to calm the resident through talking, should be taken, as well as attempts to ascertain the reasons for violence. The key is patience and understanding.

3.9 If the resident is threatening violence to property the steps, above (3.5 through 3.8) should be undertaken.

3.10 Suicide in an institution is rare, if not non-existent. If an attempt occurs, however, immediate first aid (if needed) should be rendered and a physician called for. Staff psychologists should be notified to help ascertain the reasons for the attempt.

3.11 It is imperative to make suicidal individuals feel secure. Repeated efforts to restrain and/or close observation is called for until the psychologist staff has time to complete therapy.

3.12 Any type of restraint should not injure a resident.
3.1.3 If you are moving a "disturbed" resident, make your movements known in advance so that other attendants and residents can "clear the area."

3.1.4 Never take hold of an excited resident by the hand and pull forward; the patient reflexively pulls backward and has control of his/her maximum strength.

3.1.5 If resident has a dangerous object such as a hammer, knife, etc., place first attention on that article. If necessary throw a sheet or other soft garment over the resident's head. Use a mattress as a shield.

### IV. SELF PROTECTION HINTS FOR THE ATTENDANT WHEN WORKING WITH AGGRESSIVE RESIDENTS

4.1 Be certain not to go into an isolated area unless accompanied by another employee or informing another employee where you are going.

4.2 If possible, always approach patients from the side; never stand directly in front or behind a resident.

4.3 When a resident appears upset, keep yourself calm. Retain a calm, friendly and sincere manner. Do not become upset or angry -- you will only excite the resident.

4.4 When approaching an excited resident, always make certain that you have help on hand in case assistance is needed.

4.5 Never enter a seclusion room alone. Leave the room facing a patient.

4.6 Never attempt to restrain or seclude a patient without help.

4.7 Report immediately all incidents, accidents and/or injuries.

4.8 Keep your keys in your pocket -- do not allow residents to handle them.

4.9 Always lock a door you unlock, and check to make sure that it is locked.
4.1.0 Before unlocking a door make sure no residents are loitering nearby who may attempt to escape. If a resident will not leave the area summon another attendant before unlocking.

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4.1.1 Do not permit residents to loiter in a cottage office, shower room, utility room, or secluded areas of the ward.

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4.1.2 At the sign of approaching trouble remove your own glasses (if you wear them) plus your watch, fountain pen and items of this sort.

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EXPERT PANELIST EVALUATION OF MODULE V: COMMUNICATIONS

I. CONCEPTS IN COMMUNICATION

1. Communication is defined as a meaningful contact between people. It may be either positive or negative.

2. Talking in a monologue is not a skill in communication.

3. Inadequate communication is responsible for most of the problems involving interpersonal relationships.

4. Good communication involves: (1) common sense; (2) good taste; (3) repeating oneself; (4) giving others a chance to talk; (5) listening carefully; (6) thinking before speaking, etc.

5. We ask questions in order to: (1) obtain specific information; (2) obtain suggestions and ideas; (3) to encourage a change in behavior; and, (4) to emphasize a point.

6. Examples of good telephone communications are: (1) give name and title when answering; (2) politely ask the caller his name; (3) keep pad and pencil near the phone at all times; (4) ask the caller to repeat messages you are uncertain of; and, (5) deliver the message promptly the proper party.

7. Listening is more important (sometimes) than speaking.

8. Listen to a subject's communicated content -- not his/her manner.

---

PANELIST RATINGS
(Check Appropriate Response)

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<td>1.8 Listen to a subject's communicated content -- not his/her manner.</td>
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1.9 Listening is the first step to persuasion.

1.1.0 Written communication requires; (1) knowing what you're going to say; (2) speaking correctly; (3) sticking to the subject; (4) keeping your writing legible; and, (5) keeping your report interesting and formal.

1.1.1 One of the most important responsibilities of an attendant is the developing of good communication and good relationships with the residents.

1.1.2 Communication techniques in guiding the resident are: (1) making sure the resident understands what you are saying; (2) avoiding abstraction; using simple words; (3) being alert to the emotional reactions of the resident; (4) provide the resident with reasonable directions; (5) communicating one thing at a time; and, (6) avoiding derogatory terms.

1.1.3 The attendant has the responsibility, in communicating with a resident's parents and/or guardian, to be tactful but truthful when describing a resident's progression (or regression) while under his/her care.

1.1.4 Confidentiality of resident's words is protected by law (S.B. 336).

1.1.5 Improper use of a resident's record may lead to disciplinary and/or legal action.

1.1.6 Any accidental loss or destruction of a resident's record must be reported immediately.

1.1.7 It is a violation of confidentiality if you discuss a resident's records with anyone not designated to you as having rightful access to that record.

1.1.8 It is not the attendant's responsibility to release information about a resident to anyone, other than his immediate supervisor and/or medical (nursing) supervisor.

1.1.9 Residents are permitted free and unsupervised use of the following: (1) telephone (calling and receiving); (2) sending or receiving mail without censorship; and, (3) opening their own mail and packages.
I. THE RIGHTS OF RESIDENTS

1.1 The resident has the right of freedom of choice, within his capacity to make a decision.

1.2 The resident has the right to live in the least restrictive, individually appropriate environment.

1.3 The resident has the right, as does any citizen, to express himself/herself verbally, through phone conversations and through written communication.

1.4 It is the right of the resident (or his/her parent or guardian) to refuse to participate in any phase of habilitation services.

1.5 The resident has the right to protection against exploitation, demeaning treatment, or abuse.

1.6 The resident has the right to participate in a comprehensive set of habilitative programs appropriate to his/her level of functioning.

1.7 Active treatment means an aggressive, organized effort to deliver and provide services and treatment outlined in the IHP to meet specific behavioral objectives.

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II. FURTHER, MORE BASIC CONCEPTS, ON RESIDENT RIGHTS AND ATTENDANT RESPONSIBILITIES

2.1 All retarded citizens have the right to be instructed and informed of what their IHP includes.

2.2 All activities and training in a resident's IHP should be understood by the resident.

2.3 The mentally retarded have a right to religious services.

2.4 The resident has a right to proper physical care during research projects.

2.5 It is important that the attendant be alert to any change in a resident's appearance or manifestation of pain.

2.6 A resident has the right to refuse to go to school, or to attend other activities.

2.7 If a resident receives no treatment or habilitation the hospital superintendent and other parties can be found in violation of the law.

2.8 It is inappropriate for an attendant to call a resident by any nickname the resident does not like.

2.9 As a mental retardation worker, the attendant will often have to protect the rights of residents.

2.10 Mentally retarded citizens, like any other citizens, should not be protected from failure.

2.11 The mentally retarded resident has a right to form relationships with the opposite sex.

2.12 An attendant should never strike a resident.

2.13 It is often necessary for an attendant to repeat a verbal request to a resident, in order to assure his complete understanding.

2.14 Ridicule is not an effective teaching device of the mentally retarded.

2.15 Cottage rules should be flexible and reflect individual differences in the resident population.
2.1.6 Attendants are expected to point out differences between the "truth" and a "lie" when working with residents.

2.1.7 The mentally retarded citizen has a right to her/his privacy.

2.1.8 The mentally retarded citizen is not to be treated like a prison inmate.

2.1.9 The attendant must know that the mentally retarded need affection, attention, respect, and concern for their emotional well being -- as does everyone.

2.1.10 Mentally retarded citizens must be encouraged, whenever possible to attend community activities with other community members.

2.1.11 Mentally retarded residents should feel that the employees of an institution are their friends -- and that the employees care for them as individuals.

2.1.12 Mentally retarded citizens have all the same rights as other citizens.
APPENDIX L:

Certificate of Achievement for the Mental Retardation Worker I
Ohio Department of Mental Health and Mental Retardation

James A. Rhodes
Governor

Timothy B. Moritz, M.D.
Director

Mental Retardation Worker I
Training Course

Division of Mental Retardation and Developmental Disabilities

Presented to
in recognition of successful completion of the Mental Retardation Worker I Training Course as approved by the Division of Mental Retardation and Developmental Disabilities and administered by the

given at , Ohio on this day of 1976.

Timothy B. Moritz

Director, Ohio Department of Mental Health and Mental Retardation

 ry

Assistant Director, Division of Mental Retardation and Developmental Disabilities

Superintendent
APPENDIX M

MEMBERS OF EXPERT PANEL:

LETTER OF INVITATION AND THEIR RESPONSES
January 6, 1976

As you well know, I recently began working for the Division of Mental Retardation and Developmental Disabilities in the capacity as Assistant to the Commissioner. This position is a doctoral level internship made possible by The Ohio State University Faculty for Exceptional Children (Dr. Thomas M. Stephens, Chairman).

Since the beginning of my doctoral internship with the Division, I have discussed several possible dissertation topics with Dr. Norman J. Niesen, Commissioner, Division of Mental Retardation and Developmental Disabilities, that would benefit not only myself, but the State of Ohio. The subject which I have finally chosen does appear to meet both of the criteria mentioned above. In fact, I have selected the following dissertation proposal title (with the final approval still pending until I next meet with my doctoral committee):


In an attempt to make my final attendant training program as innovative, but realistic as possible, I have concluded that a "Panel of Experts" is a necessary procedure toward the effective completion of not only the curriculum package, but of my doctoral dissertation. The panel will be charged with selecting topics and content for each curricula area. I feel, then, that this expert panel should represent a varied background in terms of experiences in working with the retarded, and in philosophy toward effective services for our mentally retarded citizens.
The purpose of this letter is to invite you to serve on my panel. I anticipate that it will not require a great deal of your valuable time, but will help me immensely. If you accept, I would hope that you would write me that you do, in fact, accept, and enclose a copy of your most recent resume. I am planning on including your resume (with your permission) in the appendices of my dissertation, as documentation of your professional expertise.

For your information, I am requesting that seven professionals serve on my panel. In addition to yourself, if you accept, I have written to the following individuals:

a. Dr. Norman J. Niesen, Commissioner, Division of Mental Retardation and Developmental Disabilities.

b. Dr. Maxine Mays, Chief, Office of Habilitation Services, Division of Mental Retardation and Developmental Disabilities.

c. Dr. Albert Z. Soforenko, Superintendent, Orient State Institute.

d. Dr. Roger Gove, State Medical Consultant, Division of Mental Retardation and Developmental Disabilities.

e. Dr. Joseph Parnicky, Professor, Nisonger Center, The Ohio State University.

f. Mr. Michael Kindred, J.D., Dean, The Ohio State University School of Law.

Please let me hear from you shortly. I believe your assistance will be invaluable, and hope that you choose to be a part of my panel.

Cordially yours,

MJE/sr

Assistant to the Commissioner

cc: Dr. W. Frederick Staub, Professor of Educational Administration, OSU
    Dr. Thomas M. Stephens, Professor and Chairman, The Faculty for Exceptional Children, OSU
    Dr. Roy A. Larmee, Professor of Educational Administration, OSU
January 21, 1976

Mr. Michael J. Elsberry
Assistant to the Commissioner
2929 Kenny Road - E105
Columbus, Ohio 43221

Dear Mike:

Thank you for your correspondence of January 6, 1976, inviting me to serve on a panel to assist you in completion of your doctoral dissertation.

I will be happy to serve as outlined in your correspondence to me and look forward to the opportunity to work with you and other members of the panel.

Enclosed is a copy of my resume.

Sincerely,

Robert L. Carl, Jr., Ph.D.

Enclosure
January 20, 1976

Michael J. Elsberry  
Assistant to the Commissioner  
Division of Mental Retardation  
and Developmental Disabilities  
2929 Kenny Road, B-105  
Columbus, Ohio 43221

Dear Mr. Elsberry:

Your letter of January 6, 1976 has been received. I appreciate the invitation to participate as a member of "Panel of Experts" in support of your work on your dissertation.

I am pleased to accept this invitation, and I commend you upon the selection of such a vital and practical topic.

I am presently revising my resume and will submit it as soon as possible.

Sincerely,

Roger J. Gove, M.D.  
Medical Consultant

RNG:peg
Attached is a resume of my various professional assignments through the years. Following is a description in greater depth of some of my activities.

I have been involved in clinical and administrative work in child psychiatry and mental retardation since 1946. Included in this responsibility has been the planning and administrative direction and coordination of a great number of long-term and short-term research projects. Included was the original committee work in planning for the development of a project involved in the study of the psychopathology and education of brain-injured children.

In later years there was a particular interest in encouraging the development of projects specifically designed to develop more effective treatment and training programs for the severely mentally retarded and developmentally disabled. This included the planning and organizing of a program for the use of physical medicine techniques and the use of conditioning methods including operant conditioning.

I was the Chairman of the Personnel Standards Committee of the American Association on Mental Deficiency which participated in the development of the 1964 Standards Manual. Subsequently, I participated in the development of the Accreditation Standards.

I participated in the development of the curriculum for Departmental Psychiatric Aide Training including the preparation of the Training Manual.

Most recently I was a member of the Technical Advisory Committee to Terminology and Classification Project of the American Association on Mental Deficiency which published the 1973 edition of the Manual on Terminology and Classification.

[Signature]

January 26, 1976
Michael J. Elsberry  
Assistant to the Commissioner  
Division of Mental Retardation  
and Developmental Disabilities  
2929 Kenny Road, Room B105  
Columbus, Ohio  43221  

Dear Mr. Elsberry:

I would be pleased to serve on an advisory panel for your project and dissertation on the development of a staff training program for Ohio's institutions.

I am enclosing a copy of my resume.

Sincerely yours,

Michael Kindred  
Associate Dean

Enclosure
January 15, 1976

Mr. Michael J. Elsberry
Assistant to the Commissioner
Division of Mental Retardation
and Developmental Disabilities
2929 Kenny Road - Room B-105
Columbus, Ohio 43221

Dear Mr. Elsberry:

I will be pleased to serve on the panel associated with your doctoral dissertation and the curriculum package you are developing. I am enclosing a copy of my most recent resume as you requested.

If I can help you in any other way, please feel free to call.

Sincerely,

[Signature]

Maxine Mays, Ed.D.
Chief, Habilitation Services

encl.
January 11, 1976

Mr. Michael J. Elsberry  
Assistant to the Commissioner  
Division of Mental Retardation  
and Developmental Disabilities  
2929 Kenny Road/Room B-105  
Columbus, Ohio 43221  

Dear Mr. Elsberry:

Thank you for your letter of January 6, 1976, in which you invite me to become a member of your "Panel of Experts."

Please be advised that I accept your invitation, and have enclosed an updated copy of my resume for your use—and information. You may, if you still so desire, include this resume in your appendices.

Thank you for your invitation. I feel that your efforts to develop new attendant training curricula will greatly benefit the Department of Mental Health and Mental Retardation, since an ineffective program is now in existence within the Division of Mental Retardation. I feel, also, that your dissertation topic will be extremely valuable to you professionally.

I hope to hear from you soon regarding the status of your dissertation proposal. Needless to say, the State of Ohio could have used the completed program "yesterday."

Sincerely yours,

Norman J. Niesen, Ed.D.  
Commissioner

cc:  DMR/DD file.  
     Dr. W. Frederick Staub, Chairman  
     Dr. Thomas M. Stephens  
     Dr. Roy A. Lampee
February 2, 1976

Michael J. Elsberry
Asst. to the Commissioner
Bldg. B, Room 105
2929 Kenny Road
Columbus, Ohio 43221

Dear Mike,

I have received your letter of January 6, 1976, requesting that I serve on a panel charged with developing a curriculum package for the training of ward attendants for Ohio's institutions.

I feel that this would be a most worthwhile project and one that would make a real contribution to the welfare of the residents of the institutions.

I would be pleased and honored to serve on a panel to help develop this project, and I enclose a copy of my resume for your use.

Please let me know when the panel will be meeting, and I will be happy to attend.

Sincerely,

[Signature]

A. Z. Sotrenko, Ph.D.
Superintendent

AZS:1je
APPENDIX N

SUMMARY EVALUATION OF WWPI
APPENDIX N

Ohio Department of Mental Health
and Mental Retardation
James A. Rhodes, Governor
Timothy B. Moritz, M.D., Director

March 31, 1976

MEMO TO: John Santoso, Assistant Superintendent, ACSI
        Robert Moorehead, Training Officer, DMR/DD
        Terry Hendrick, Program Director, Tiffin
        George Khoury, Program Director, OSI
        Brian Haller, Program Director, CSI
        Dennis Wool, Unit Chairman, OSI

FROM: Michael J. Elsbree, Commissioner

SUBJECT: Attendant Performance Scale

I am attaching the final revision of the attendant performance inventory, for your final review and comment. I felt that our meeting in early March was productive, and your suggested revisions are reflected in this final draft.

A rating scale is attached, and I would appreciate your mailing me your reactions at your earliest convenience. It is merely a checklist in which you respond with the most appropriate comment. For your information, the checklist appears as:

HI=Highly Important.
I=Important.
NSF=No Strong Feelings.
NI=Not Important.

I would appreciate your comments. Thanks again for your assistance.

MJE/pg

cc: Norman J. Nielsen, Commissioner
    Division of Mental Retardation and Developmental Disabilities
CIRCLE THE CORRECT RESPONSE—BASED ON YOUR OPINION.

RATING FORM: WORKER PERFORMANCE INVENTORY

1. When the worker is assigned to direct-care work, how much of this time does he actively spend working with the resident?

   HI   | NSF | NI
   ---- |-----|----
   5    | 0   | 0

2. Converses or talks appropriately with the residents.

   HI   | NSF | NI
   ---- |-----|----
   3    | 2   | 0

3. Spends part of his/her time teaching the residents on the unit those tasks necessary for them to learn in order to function more independently.

   HI   | NSF | NI
   ---- |-----|----
   5    | 0   | 0

4. Shows respect of the resident's individual rights as people.

   HI   | NSF | NI
   ---- |-----|----
   4    | 1   | 0

5. Uses correct terminology in describing the resident's behavior and/or condition.

   HI   | NSF | NI
   ---- |-----|----
   2    | 2   | 1

6. Responds appropriately (comforts, supports, etc.) to the emotional needs of the resident.

   HI   | NSF | NI
   ---- |-----|----
   2    | 3   | 0

7. Carries out his/her unit tasks expected by his/her supervisor.

   HI   | NSF | NI
   ---- |-----|----
   3    | 1   | 1
8. Does more than is expected of him/her without being told.

HI  I  NSF  NI
  0  5  0  0

9. Has the ability to function in the absence of direct supervision.

HI  I  NSF  NI
   1  4  0  0

10. Has the skills to function in the absence of direct supervision.

HI  I  NSF  NI
   1  4  0  0

11. Has a positive attitude to function and adapt to the demands of the job.

HI  I  NSF  NI
   3  1  1  0

12. Cooperates with his/her fellow workers and other institution employees.

HI  I  NSF  NI
   2  3  0  0

13. Follows the institution and unit rules.

HI  I  NSF  NI
   3  2  0  0

14. Independently controls and directs the correct behavior of the residents under his/her responsibility.

HI  I  NSF  NI
   4  1  0  0

15. Follows the correct procedures for resident safety (correct techniques of injury-prevention).

HI  I  NSF  NI
   5  0  0  0
16. Follows the correct procedures for preventing injury to self and others.

   HI  I  NSF  N1
   2  3  0  0

17. Functions effectively in an emergency situation.

   HI  I  NSF  N1
   2  3  0  0

18. Accomplishes the daily housekeeping procedures of his/her unit.

   HI  I  NSF  N1
   1  4  0  0

19. Interacts appropriately with a particular resident’s family; other unit visitors; and, the general public.

   HI  I  NSF  N1
   3  2  0  0

20. Adequately meets the requirements of his/her work schedules.

   HI  I  NSF  N1
   3  2  0  0
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