

ASSESSMENT AND MANAGEMENT OF THE WANDERING PATIENT

Overview

The wandering patient is a problem both in the home and the nursing home. Wandering behaviors will occur in 25-50% of demented patients and this symptom is most common in the middle stage of dementia. Wandering can be broken into several categories including 1) patients who attempt to escape, 2) patients who rummage, 3) patients who roam through the unit or the home, and 4) patients who visit. The treatment of wandering behavior begins with a careful assessment of the problem. The family or treatment team should carefully monitor the patient's behavior over a 7-10-day period, during which there are no new medical problems. The team should note the type of wandering, frequency, duration, time of day as well as other behaviors associated with these episodes. The family should keep a diary or the treatment team should record each type of information in the medical record to develop a composite picture of the patient's behavior. The treatment options for wandering behaviors are based on the causes and clinical features of this disruptive activity. While some patients are best treated with antipsychotic medications, most causes require behavioral interventions. The treatment team of a nursing home or assisted living facility must determine whether the wandering is new or old. Patients who are recently admitted into a facility may wander as they orient themselves to the facility and the treatment team should attempt to monitor the patient for several weeks after admission to determine his baseline level of activity. Patients who begin to wander after a prolonged period of stability in a facility suffer from some new complication – medical, psychiatric or cognitive. Delirium may produce the abrupt onset of wandering behavior. Delirious patients may seem more confused and these individuals are at risk for falls or injury. The staff should observe when the patient begins to wander during the day to assess whether environmental stimulation such as yelling or movement on the unit precipitates the behavior. All wandering patients should be placed on a toileting, feeding, and hydration schedule. These individuals may be seeking a bathroom, food or water. The toileting should include direct assistance with disrobing and placing the patient on the toilet as patients may have forgotten these skills. Food should be placed directly in the patient's hands. Hydration should include placing a cup up to the patient's lips.

For the patient who was newly admitted to the facility, the staff must determine the patient's activity level prior to admission. Patients who were physically active prior to admission or those who spent a great deal of time outdoors are likely to require exercise on a regular basis outside the facility. Some patients will follow other wandering patients. Some wandering individuals will lead other patients by the hand.

Treatment should focus on separating the patients and treating the wanderer. Patients who struggle during redirection should be assessed for aphasia and psychosis. Patients with impaired communication will require non-verbal communication to redirect.

DIAGNOSIS

EXIT-ORS

Patients who attempt to flee the facility may be confused or psychotic. Confused patients are unable to orient themselves in the nursing home or assisted living facility and these individuals require constant reassurance and surveillance to maintain calm. Patients who are attempting to flee because of delusions or persecutory hallucinations are best treated with antipsychotic medications. The target symptoms are hallucinations or delusions—not wandering. Exitors should have safe-return identification and staff should regularly check for their locations. Patients who want to “go home” are rarely improved by visits to their last residence or ancestral home. Most patients will not recognize their home and they will attempt to flee their old residence as well.

ORBIT-ORS

Some patients will wander around the facility and return to the nursing station where they will check-in and repeat the pattern, i.e., orbiting. The team must determine whether the movement is continuous or episodic. Episodic movement by a patient may represent hunger, urinary or fecal urgency, pain, fear or frustration. Alzheimer’s patients frequently eat small amounts at each meal and the patients are frequently hungry between meals. Restless patients may be hungry and multiple snacks may lessen this motor behavior. Many patients drink insufficient quantities of liquids and wandering may result from thirst. Patients may forget how to use a water fountain and these individuals may no longer recognize a water pitcher, glass or straw. Wandering may result from physical distress. Chronic pain occurs in approximately 25% of Alzheimer’s patients in nursing homes and these individuals frequently lack the ability to request pain medications. Patients with pre-existing painful conditions such as arthritis or angina, require appropriate medications to suppress these symptoms.

Patients may have episodes of wandering due to boredom or frustration. These individuals require specialized recreational programming. Behavioral interventions such as music groups, exercise programs, movies or van rides that consume large amounts of a patient’s time are a first step in dealing with restless patients. Music therapy can be highly effective in quieting excessive motor behavior. Families should be contacted to confirm that recreational programming is consistent with the patient’s premorbid lifestyle.

Continuous motor activity may result from the same causes as intermittent activity; however, the staff should consider other possibilities. Psychotic patients experiencing hallucinations may be distressed and demonstrate significant motor agitation. Similar symptoms may be present with delusions. Agitated, depressed patients may develop anxiety as a consequence of their depression. These individuals oftentimes appear distressed and may yell or scream as they orbit the unit.. These patients are best treated with antidepressant medications. Anxiety is poorly treated with benzodiazepine medications such as Valium, Ativan, etc. These drugs often make the patient more confused, more agitated, and more likely to strike out during redirection.

Patients who receive typical antipsychotics, e.g., Haldol, Prolixin, etc., are at significant risk for developing akathisia. Patients receiving drugs like Haldol or Navane may develop an inner sense of restlessness similar to an intense level of anxiety. These patients will pace or dance in place. The atypical antipsychotics, e.g., Olanzapine and Seroquel, have fewer tendencies to produce akathisia than older standard antipsychotics. Akathisia should be treated with either dose reduction or switching to an atypical antipsychotic. Patients can also be treated with Inderal (30mg PO BID), provided they do not have complicating pulmonary or cardiovascular disease.

Sundowning is agitation and restlessness occurring in the late afternoon or early evening. This behavior responds poorly to medications. Sundowning is produced by damage to neurons (i.e., nerve cells) in deep nuclei and the brainstem that control biorhythms. The use of tranquilizers or sleeping pills in the evening rarely normalizes the sleep pattern. These patients require specialized programming to accommodate their increased activity in the p.m. The goal is to keep these patients safe and out of other individuals' rooms who are attempting to sleep.

RUMMAGE-ORS

Rummaging behavior is less common than orbiting, but this symptom can produce chaos on a unit. The rummaging patient will enter another patient's room and search through drawers or closets. Most patients rummage because they are bored and confused. Recreational activity can lessen this behavior and some units have specific "rummaging rooms" for these patients. Some patients rummage in specific rooms because of delusional beliefs, e.g., the rummager is married to the occupant. This patient may benefit from psychotropic medications for delusional ideas. Antipsychotic medications are not used for rummaging behavior unless there are specific delusional beliefs that produce the behavior.

VISIT-ORS

Some patients will wander through the unit and enter other patient's rooms to socialize and visit. These patients are often bored, under-stimulated, or seeking human companionship. Visit-ors require structured recreational activities and increased human contact with family, friends, staff or other residents.

TREATMENT

The treatment of the wandering dementia patient depends on the type and severity of this behavior. Some interventions may help all wandering patients (See Decision Tree), while other interventions are focused on very specific types of wandering.

One goal of therapy for all wandering patients is to prevent intrusion into other residents' rooms. Large, colorful signs with the patient's name that are individualized may help patients re-orient. Similar signs should be placed over bathrooms.

Specific boundary markers such as *stop signs* and *crosshatches* on the floor may lessen the likelihood that some patients attempt to leave. A wander-guard system, i.e., electronic warning system, is more effective and safer for these patients. The systematic assessment of wandering patients followed by behavioral, medical, and pharmacological interventions can reduce disruptive behaviors in most patients and assures unit safety. A very small group of patients persistently and aggressively wander. These individuals may become hostile during redirection and create chaos on the units. Such patients should be referred to specialists with expertise in geriatric psychiatry or behavioral neurology for a more detailed assessment and recommendations for psychotropic medications. Some patients will crawl into bed with other patients, much like small children climb into bed with parents. Bed-sharing is not a sexual act; however, this behavior can lead to confrontations and angry complaints from families of both patients. This behavior is managed by observation, re-direction, and time-supervision.

Federal guidelines prohibit the use of psychotropic medications for "wandering" or "intrusive" behavior in nursing homes. Hallucinations, delusions, or impulsive behavior that results from brain damage, as well as depression, and anxiety are appropriate target symptoms for the prescription of psychoactive medications. Once these psychotropic medications are prescribed, the target symptoms must be measured and recorded. A behavioral intervention is indicated to minimize wandering in patients who demonstrate improved mood or psychotic symptoms but continue to wander. Psychotropic medication should not be increased to treat wandering once the psychiatric symptoms are eliminated. There is no indication for the use of antihistamines, e.g., Benadryl, Vistaril, etc., or benzodiazepines to reduce

wandering behavior and restraints are specifically prohibited for any type of wandering activity.

CONCLUSION

Wandering is a common behavior in patients with mid-stage dementia. Long-term care providers should know basic facts about wandering (See Fact Sheet). Management of the wandering patient begins with a thorough assessment and the treatment team should ask questions prior to initiation of therapy (See 10 Basic Questions). Treatment includes behavioral, medical and pharmacological interventions.

10 QUESTIONS ABOUT WANDERING

1. WHEN DID THE WANDERING BEGIN?

Patient may have been moved from one room to another and now he/she is disoriented. If it's a slow incremental increase in wandering then that's most likely secondary to the dementia.

2. WHEN DOES THE WANDERING OCCUR DURING THE DAY?

If they are wandering in the p.m. or early evening, this may be sundowning. If they are wandering first thing in the morning, they may be hungry. If they are getting up in the middle of the night and wandering, they may need to go to the toilet.

3. IS THE PATIENT AN ORBIT-OR, RUMMAGER-OR, EXIT-OR, OR VISIT-OR?

4. HOW LONG HAS THE PATIENT BEEN IN YOUR FACILITY?

Patients become habituated to your program after several years. If they are new arrivals, wandering may be a mixture of disorientation and changes of behaviors. Patients do remember old habits.

5. WHAT DOES THE PATIENT DO ON AN AVERAGE DAY?

What does the patient do all day. Does the patient have large amounts of idle time?

6. WHAT WAS THE PATIENT'S AVERAGE DAY LIKE BEFORE THEY CAME INTO YOUR FACILITY?

Did the patient get a lot of exercise? Did they do a lot of walking or other activities that consumed time?

7. DID YOU USE THE BEHAVIOR CHECKLIST?

Example: Pain, fear, hunger, bladder, bowel, boredom (See Page 9 and 10).

8. DID YOU CONSULT THE RECREATIONAL THERAPIST?

Boredom and social isolation can be improved with structured activities that fatigue patients and consume their time.

9. HOW MUCH ENVIRONMENTAL CHAOS IS ON THE UNIT AND WHEN DID THIS DISTURBANCE BEGIN?

Patients respond to environmental stimulation. A screaming roommate may agitate an otherwise calm resident. Loud noise or music may provoke a similar response.

10. WHAT IS THE STAFFING SITUATION AND HAS THE PATIENT'S CNA OR CAREGIVER BEEN CHANGED?

Poorly trained or new staff may provoke anxiety or agitation that provokes wandering.

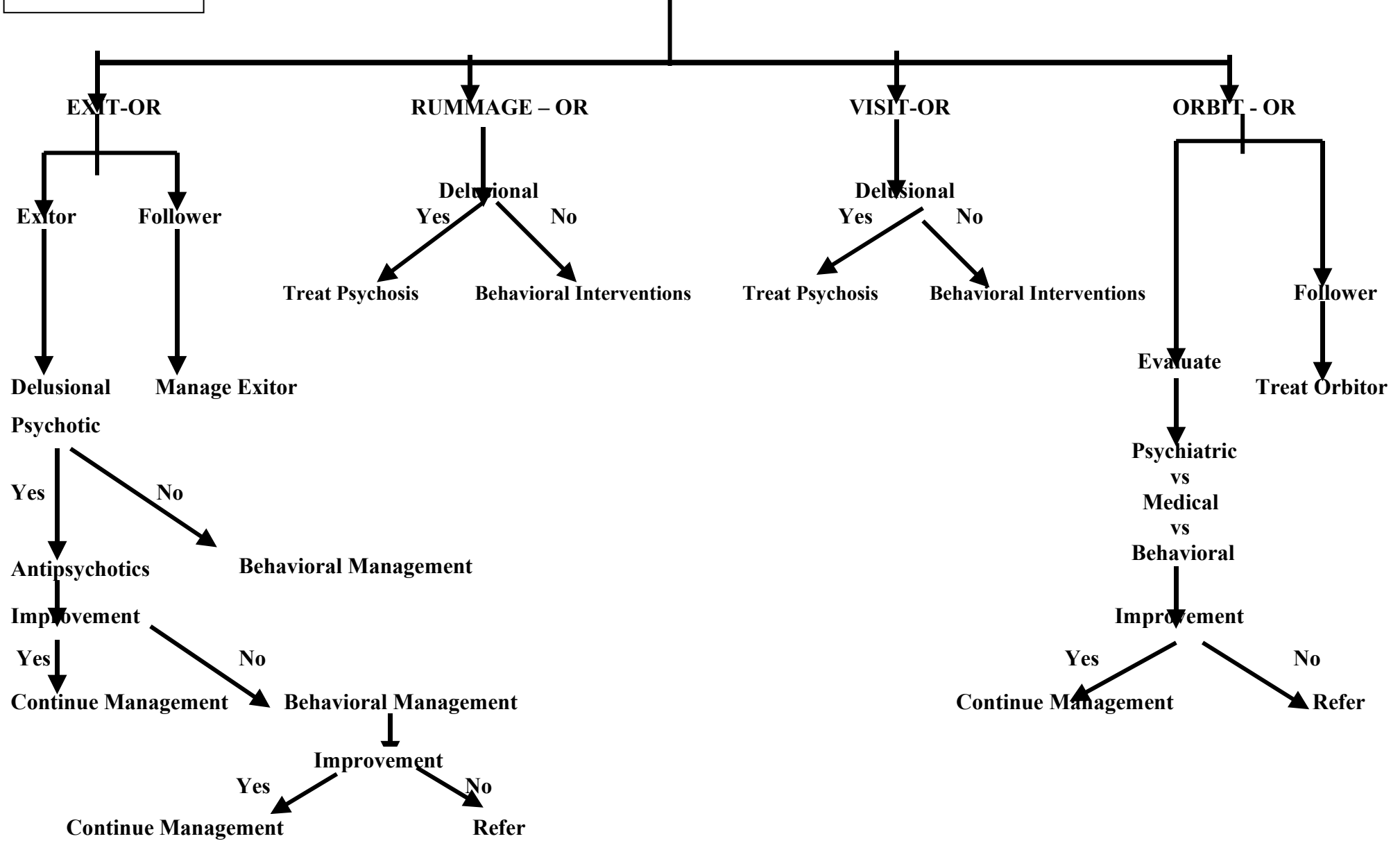
FACT SHEET

ON WANDERING

- 1. Wandering is common in patients with middle-stage dementia.**
- 2. Wandering behaviors include attempting to leave, roaming, visiting, and rummaging.**
- 3. The first step in treating wanderers is a careful assessment to determine the cause.**
- 4. Some patients follow wanderers.**
- 5. Most wandering behavior is best treated with behavioral intervention.**
- 6. Common physical causes of wandering include hunger, thirst, and urinary or fecal urgency.**
- 7. Pain, boredom and social isolation are common causes of wandering.**
- 8. Recreational therapists are key to reducing the intensity wandering behavior.**
- 9. Some demented patients wander because of hallucinations or delusions and these symptoms are best treated with psychotropic medication.**
- 10. Nursing homes should not use psychotropic medications or restraints to treat wandering.**

Decision Tree

WANDERING



BEHAVIORAL CHECKLIST FOR DEMENTIA PATIENTS

SYMPTOMS	CAUSES	INTERVENTIONS/TREATMENT
(1) WANDERING	Disorientation Anxiety/Boredom Urinary/Fecal Urgency Hunger Rectal Impaction	Recreational Activities Recreational Activities Toileting Schedule Frequent Feedings Remove Impaction
(2) YELLING	Boredom Fear Pain Depression Psychosis Anxiety Hunger Fatigue Sensory Impairment Delirium Rectal Impaction	Recreational Activities Reassurance Analgesic SEE DEPRESSION FACT SHEET SEE PSYCHOSIS FACT SHEET Recreational Activities Feedings Naps Check Vision and Hearing SEE DELIRIUM FACT SHEET Remove Impaction
(3) VERBAL OR PHYSICAL THREATS	Fear Disorientation Fatigue Hunger Pain Delusion Aphasia Rectal Impaction Delirium Sensory Impairment	Reassurance Reorientation and Reassurance Naps Feed Patient Analgesics SEE PSYCHOSIS FACT SHEET Non-verbal Communication Remove Impaction SEE DELIRIUM FACT SHEET Check Vision and Hearing

SYMPTOMS	CAUSES	INTERVENTIONS/TREATMENT
(4) INCONTINENCE	Disorientation UTI Medication GU Problem Delirium Rectal Impaction	Toileting Schedule Treat UTI Change Medication Urology Consultation SEE DELIRUM FACT SHEET Remove Impaction
(5) STEALING	Disorientation Delusions	Recreational Activities SEE PSYCHOSIS FACT SHEET
(6) DISROBING	Amnesia Apraxia Anxiety Delirium	Recreational Activities Jumpsuits Recreational Activities SEE DELIRIUM FACT SHEET
(7) WEIGHT LOSS		SEE WEIGHT LOSS HANDOUT
(8) AGITATION		SEE AGITATION HANDOUT
(9) REPETITIVE QUESTIONS	Amnesia Boredom Aphasia	Recreational Activities Recreational Activities Non-verbal Communication
(10) POOR HYGIENE	Apraxia Aphasia Psychosis	SEE BATHING HANDOUT Non-verbal Communication SEE PSYCHOSIS FACT SHEET
(11) FALLS		SEE FALLS FACT SHEET AND HANDOUT
(12) MISIDENTIFICATION OF CAREGIVER	Agnosia Delusions	Tolerance SEE PSYCHOSIS FACT SHEET