3-224 Agitation and wandering

TIPS Question:

What suggestions would you have for working with a LTC female resident age 72 with dementia, CVA, diabetes and who has frequent episodes of agitation and wandering? Upon admission her MMSE was 11 and she was in a wheelchair. Her MMSE is now above 20 and she now is up walking with a walker. She is placed in a wheelchair with a pelvic restraint as she is at risk for injury. When agitated she will walk quietly around the halls until diaphoretic and weak (her normal gait is a shuffle and leans to left). Whether in wheelchair or walker she will wander out of the building or lock herself in her room.

What are the significant factors you have learned as a result of working through the six-question template?

- The more cognitively impaired the resident the more environment accounts for her behaviour. Also you are made aware that all behaviour has meaning. The higher the activity and noise can trigger her agitation
- With the DOS you realize that her agitation episodes more frequently happen in the afternoon or at suppertime. At times will refuse to eat as she is going out for a meal or she has eaten R/T anosognosia and delusional.
- She believes whatever to be true and factual and becomes defiant and resistive to care and suggestion – I now realize she is not in denial but acting upon what her brain is telling her to be true.

Response:

In a situation such as this, care teams often want to examine risk as safety appears to be the most immediate issue. As you work through the RISKS template you and the care team can determine the degree of risk as related to her wandering behaviour. With her improved level of mobility she may need to be re-assessed regarding the appropriateness of the unit she is on. Your facility probably has a protocol ensuring sufficient safety measures are in place – wandering bracelet, alarm bracelet, magnetic locks on the doors, etc. It is also recommended that you discuss the implications of her wandering risk with her family. It is important to note that although her MMSE score has improved that is not indicative of her ability to reason, have insight or that her judgement is unimpaired.

After staff feel more comfortable that the degree of risk has been assessed and the appropriate interventions taken, then her behaviours can be further examined. The U-First! wheel would be very valuable to use with the team to both collect information and develop more *understanding* of the complex challenges this resident faces. You correctly identified that all behaviour has meaning and the more cognitively impaired an individual is, the more the environment impacts behaviour. Your statements indicate a good understanding that the behaviours this woman exhibits are a result of many factors that she may not be able to control. When staff understand this, most of the difficulty is dealt with, as staff feel less frustrated and stressed.

You have *flagged* some of this resident's *intellectua*l and *physical* changes. Regarding her physical status you have noted her diabetes. Do her blood sugars have any correlation with her behaviour? Is her intake sufficient at lunch and snacks? As you identified, she may lack the ability to connect her fatigue with the need to rest. Frequent rest periods or the use of the wheelchair for short periods may be necessary to prevent injury. The DOS will help you pinpoint times that she may need more food or rest.

You may want to help staff understand her strengths and deficits and apply this knowledge to their *interactions* with her. Remind staff that they will have better interactions with her if they do not confront her beliefs. Have family and other partners in care assist with *developing supportive care* interventions i.e. phone calls to family, postcards, mail, and other distractions can be developed for this resident. Once the P.I.E.C.E.S. have been collected and understanding of this resident as a person is enhanced, then staff start to see the behaviours in a different light. The re-framing of the behaviour and alterations in interactions will decrease the resident's agitation, and lower the staff's stress.

Please note: *TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*