3-688 Exiting behaviour

TIPS Question:

In the facility I work in an unlocked Dementia Unit. A problem we are experiencing is the following. Mrs. M. wanders off our unit without exaggeration 20 plus times per shift to another unit down the hall. This is disruptive to the other unit as she goes at night too, turns on lights. Residents have yelled at her and even hit her. It is virtually; physically impossible to catch her every time as it is a 25-bed unit with 3 staff on my shift. She takes Risperdal 1 mg. 0800 and 2mg. QHS. Do you have any suggestions for exiting? Locking the unit is not an option to us.

Response:

This is a behaviour that is very time consuming to staff and must be very frustrating. I can see that it would be a benefit to quickly go through the 6-question template:

1. What is the behaviour-cognitive mental health need?

   You have identified exit-seeking as the main concern with this lady.

2. Who is it affecting?

   This is very important. There are many Partners in Care involved: the client, family, the nursing staff, co-residents, family physician, community partners. It would be important to discuss with staff who they think the behaviour is affecting. The exit seeking obviously affects this lady. Are there families that are quite concerned? It appears this behaviour affects the co-residents, as they are aggressive with her. Except for time how else does this exit-seeking behaviour affect the staff, or does it? When you discuss whom this behaviour is affecting with your care team, detail *why* they are affected.
   This helps later when you discuss potential interventions.

3. What is the degree of RISK?

   This framework will help prioritize the issues.

   R: roaming: obviously this lady is at risk for roaming. You mentioned that it is to another unit. Is it always the same unit and the same place? If so, I assume this may decrease the intensity of risk because you would have a pretty good idea where to find her. Is there a risk of her going elsewhere, possibly outside? Talk to your staff about the worst case scenario. If she left, where could she end up? Look at how your unit is situated regarding the outside environment and other safety risks. Can precautions be taken to lower risk if she elopes?

   I: imminent risk: fire/falls/frailty. From your information there does not seem to be a great risk in these areas. Is she falling? Are there stairs she could fall down?

   S: suicide: this does not appear to be an issue with this lady, based on your information

   K: kinship: risk to/from others. It appears that this lady is at risk from co-residents when they respond aggressively to her behaviours. Exactly what behaviours set off the co-residents, is it the wandering or just turning on lights? Is it the same co-residents who get aggressive? If so, is there anyway you can change the environment to minimize the opportunities for this lady to frustrate the co-residents? I.e. can you put tape over the light switches? Move the co-residents to another section, further down the unit?

   S: self neglect: from your information, this does not seem to be an issue.

   If the actual degree of imminent risk were low, this would help staff relax, step back, and work through these issues in a systematic way.

4. How do we describe and record what we see?

   I don't know if you were able to use any tools. A Cohen-Mansfield Agitation Inventory (CMAI) would be very valuable. You would be able to get a clear understanding of exactly what

behaviours are occurring. It is recommended to have each shift fill this out to determine if there are different behaviours for different shifts/staff. After it is determined exactly what the behaviours are, it would be beneficial to complete a DOS (Dementia Observation System) for approximately three days. This would show pattern in more detail. For this particular client this is very important because then you would be able to see the actual frequency, time of day, etc. that these exit-seeking behaviours are occurring. Staff usually state that they are surprised after completing the DOS, as they are surprised to see a pattern, and that the frequency is sometimes lower than originally thought.

5. What are the possible causes?

   Physical: I assume your team has ruled out possible physical causes. Sometimes physical issues do not *cause* the behaviours, but the behaviours are worsened. Check to see that this client is at her best physically and then target the behaviours. Does the staff know the implications of her physical complications, if any?

   Emotional: Look for possible depression. Remember that older people may deny feeling depressed but are more irritable/agitated. A Cornell Depression Scale or SIGECAPS can lead the assessment. Have her assessed for her anxiety level, especially since this seems to trigger these types of behaviours.

   Intellectual: This is a good opportunity to first ask staff what they think this client's cognitive status is and then present results from such assessments as the Folstein Mini Mental Status Examination and the Clock Drawing Test. Often staff over-estimate a client's abilities. Acknowledge that her cognitive status may fluctuate throughout the day as well. From your behaviour mapping you would see her best/worst times of day. It would be important to ascertain the intellectual capabilities of this individual before determining a response to her behaviours. Survey the staff and see if any are reporting that 'she knows better than this' or 'we've told her a million times and she's not listening'. These would be very important comments because you could see if staff are expecting too much from her. Get a sense of other cognitive deficits she may have and see if you can use them to your advantage. E.g. if she has a loss of depth perception then you can try putting a wide black stripe on the floor in front of the doorway to use as a barrier. You can try disguising the door by painting it the same color as the walls or painting a mural on it.

   Capabilities. Sometimes it is not easy to identify a resident's strengths. When you talk to staff and family try to brainstorm on strengths this individual has, i.e. can she do any part of care by herself, are there activities/people she enjoys, does she have any cognitive strengths?

   Environment. As mentioned earlier, can the environment be changed to cut down on the frequency and risk of her exit-seeking behaviours? Is the door an environmental cue in itself that draws her to it? In looking at your behaviour charting, are there times that she exit seeks more and does it have to do with the environment? I.e. during noisy/ high stimulation times?
   There are alarm systems available where a particular resident wears a sensor, another sensor is set up a certain distance from the door. As the resident approaches the door, the alarm is activated, giving staff enough time to re-direct the resident before she exits. Perhaps this is an option for your staff since the door cannot be locked.
   What is this lady's quality of life? You would get an idea of how much meaningful activities she has in a day from the DOS charting. Sometimes residents are drawn to the door for lack of any other activity in which to engage.

   Social. Is there any staff that feel they have better interactions with this lady especially when re-directing her back to the unit? If this is the case, maybe this staff could be assigned as the main 're-directors' when she goes to the door. This would lead to more consistency for the resident.

6. What are the steps for providing the best care strategies?

   Meet with the team, share your information and discuss the following:

1. The possible causes for these behaviours. All behaviour has meaning and you and the care team need to discuss what Mrs. M. is trying to tell you. Do not forget that there are multiple reasons for behaviours. Brainstorm with the group and see what you come up with as possible causes. Usually this type of behaviour is due to cognitive impairment. When individuals are confused and have difficulties 'putting their world together' they become more agitated. This resident may be experiencing a "drive" to pace and exit-seek. Such a drive, or feeling, cannot be easily decreased simply by our response to them. In other words, she may feel driven to exit-seek and it doesn't matter how many times she is re-directed and told "no", she will keep performing the behaviour in an effort to decrease the agitation she may be feeling. Also, getting to know her past is often helpful. Is she looking for her children/parents/spouse? Does any of her past activity relate to her present behaviour?

2. Try to alter the environment to decrease the behaviours, rather than trying to change the client's behaviour. Specific suggestions were made earlier, but discuss with staff more potential changes. It is always disappointing to use a pharmacological intervention to stop a behaviour that wouldn't be a problem if the environment could accommodate it.

Talk to staff about their perception of the behaviours. It is very difficult to have staff speak openly when there is disagreement about what they think is causing the behaviours. Remind the staff that everyone is concerned about the exact same thing, and that is this resident's care and quality of life. If everyone views this situation from the resident's point, then there is a better chance of a positive outcome. The positive outcome may be less frequency of exit-seeking behaviours or simply staff working toward giving this lady more opportunity to decrease his agitation.

Perhaps it would be helpful to share the "Train Journey" story that was read aloud during P.I.E.C.E.S. training (found in the Dawson and Wells reference of the Abilities Assessment Instrument). It talks about how it feels for an individual to not understand why they are being 'held in captivity' and their efforts to get away. Difficult behaviours are exhausting for staff. Validate their feelings on this topic. When staff feel supported, it increases their reserve to deal with complex situations.

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.*