Behaviour Management
A Guide to Good Practice

Working with people with dementia who present with wandering

A presentation for residential aged care staff and community care staff prepared by the Dementia Collaborative Research Centres (DCRC-ABC) with the assistance of Sharon Wall for the Dementia Behaviour Management Advisory Services (DBMAS)

Objectives
At the end of this presentation participants will have an increased understanding of:
- How wandering behaviours present in people with dementia
- Diagnostic criteria & potential causes of wandering behaviours in people with dementia
- Strategies & considerations to assist in the care of people with wandering behaviours in dementia

What are wandering behaviours in dementia?
- Repetitive locomotion
- Lack of awareness of boundaries & obstacles → person with dementia at risk of harm
- May lead to:
  - exiting
  - elopement &/or
  - becoming lost

What do wandering behaviours look like in dementia?
- Trailing
- Pottering
- Aimless walking
- Night time walking
- Inappropriate walking
- Increased motor activity
- Attempts to leave facility/home
- Appropriate, but excessive walking
  …contribute to excess disability

Many potential areas may contribute to wandering in dementia

Acknowledgment of Country
We acknowledge the traditional custodians of this land
We also pay respect to the elders past and present and extend that respect to other Aboriginal people present

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Wandering in-service

Wandering has different meanings & causes for each individual

Wandering behaviours may be caused by a complex interaction of:
- changed environment → disorientation
- escaping surrounding noise
- excess energy
- an expression of boredom
- confusing night with day
- physical &/or emotional discomfort
- ‘a job to do’ – confusion with past roles

Diagnostic Considerations
Using a person-centred approach, gather ALL potentially important information

- Is the wandering behaviour due to pain/discomfort, physical illness/injury or other physical causes?
- Could this be a symptom of depression, agitation, psychosis or delirium?
  If YES, respond & treat accordingly FIRST

Differential diagnosis for wandering behaviours in dementia
- Wandering often classified within syndromes of agitation & restlessness
- Anxiety & low mood may contribute – should be excluded as potentially treatable causes

Measuring wandering in dementia
Instruments to assist:
- Neuropsychiatric Inventory (NPI)
- Cohen Mansfield Agitation Inventory (CMAI)
- Revised Algase Wandering Scale for Long Term Care (RAWS-LTC) & Community Version (RAWS-CV)

Prevalence of wandering in dementia
- Reported range 12.3 – 63%
- Rates vary due to unclear definitions
  Men & YOD
  AD compared to VaD
  Those with greater cognitive impairment
  Random locomotion in AD
  Pacing & lapping behaviours in FTD
Prevalence of wandering in dementia cont.
- Rate & duration of wandering increases as cognition declines
- Then decreases in later stages
- Increased frequency associated with
  - greater independence in mobility
  - greater dependence in ADLs

Effects of wandering in dementia
- Early entry into RACF due to ↑ carer burden & anxiety around risks
- Locked doors → distress, frustration
- Alarms, surveillance devices → agitation
- Falls, injury &/or fractures
- Weight loss
- Resident to resident violence
- Use of restraint
- Social isolation

Potential adverse effects of wandering in dementia
- Wandering residents may incite others to wander
- Absconding
  - can lead to becoming lost, with adverse health effects
  - more likely to occur at mealtimes &/or staff changeover in RACF

Potential positive effects of SAFE wandering in dementia
- Provides exercise → improved circulation
- Therapeutic benefits:
  - appetite
  - mood
  - sense of wellbeing & agency
  - feelings of empowerment & control
- boredom

Encourage safe, independent walking, unless …
- safety is threatened
- physical exhaustion results
- increased discomfort occurs
- adequate fluid &/or food intake disrupted

Before you move on, have you:
- ensured that the person & all in their environment are not at any risk?
- provided a full person-centred assessment of the presenting symptoms?
- excluded &/or treated any potentially reversible factors
Your approach
Wandering behaviours can be distressing, so be...
• Calm
• Gentle
• Thoughtful
+ • Work with the feeling
  • Ensure comfort
  • Take your time
  • Look behind the behaviour

Caring approaches & interventions
First line response:
Psychosocial &/or environmental e.g.
• Touch therapies
  – neck & shoulder massage
  – slow stroke back massage
• Aromatherapy oils
• Ambient room lighting
• Proximity to other people

First line approach cont.
• Addressing emotional needs
• Positive social interaction
• Strength/ balance exercises
• Variations in sound levels
• Behavioural reinforcement → reduced wandering at meals

Subjective/ environmental barriers
• Aim to reduce exiting behaviours
• Typically involve 2-dimensional manipulation of environment including
  – grid patterns on floors
  – mirrors
  – concealment
  – camouflage techniques

2nd line approach – biological
• Treat underlying depression &/or pain
  Where pharma is prescribed:
  • Use with caution – short term only
  • Use in combination with psychosocial interventions
  • Be aware of risks
  • Monitor closely
  • Reduce, discontinue when indicated
  • REVIEW!

Pharmacological &/or physical restraint
Physical restraint can lead to increased aggressive behaviours
NB: the use of pharmacological &/or physical restraints to manage wandering is unethical
Attempting to reduce wandering with sedation can lead to:
- confusion
- falls & motor restlessness

NB: restlessness has been linked to side-effects of psychotropic medications
- The use of Antipsychotics is NOT justified

Technology/monitoring systems
Can be used in community & RACFs to:
- alert carers when attempts to exit are made
- help navigate person with dementia to a safe location
- disguise exits
- notify carer of location
- alert emergency services

A clinical scenario - Mr E

Mr E presentation
- 63 year old Aboriginal man
- At 16, moved from regional community to Adelaide
- Lived with wife until her death several years ago
- Has 5 children & strong community links with his original Country
- Supported at home by family, community members & Aboriginal-specific community service

Mr E presentation cont.
- 3 x in past month - found after dark, inappropriately dressed for weather & distressed
- Most recent occasion → disorientated → police called → uncooperative & verbally aggressive
- Daughter located to collect him from local police station

Mr E
What are some of the potentially contributing factors for Mr E’s wandering?
Mr E – potentially contributing factors

• Unreported pain/discomfort/illness/infection/constipation
• Medication interactions, dosage, adverse effects
• Potential triggers in his environment

Potentially contributing factors cont.

• Underlying depression
• Lack of stimulation/boredom
• Changes to his physical environment
• Searching for family members/childhood home environment

Mr E

With the potentially contributing factors in mind, what aspects of Mr E’s situation could be important in your assessment?

Mr E – assessing the situation

• Encourage Mr E to express his needs as far as he is able
• Arrange medical/pharmacological review to exclude potentially contributing factors
• Directly observe situations which precede wandering & those when he appears settled

Mr E – assessing the situation cont.

Consult:
• community workers about situations they have identified which may provoke wandering
• life history
• family members about strategies they may have identified that discourage wandering

Mr E – some outcomes
Wandering in dementia – conclusions

• Multidisciplinary, individualised, multifaceted approach ALWAYS!
• Reduce &/or treat possible physical causes
• First line approach – individually tailored, psychosocial interventions
• Some evidence for environmental interventions, aromatherapy & touch therapies
• Chemical restraint with medication - not recommended

‘Success’

• Typically not about eliminating BPSD
• Has BPSD?
• Has person with dementia’s distress?
• Has carers’ understanding of potential causes?
• Has carers’ skills/coping?
• Do carers feel supported?
• Be realistic about goals/outcomes
• BPSD are SYMPTOMS of dementia!

Reflection & review

How can you use this information to make a difference in the lives of people with dementia who present with wandering?

Thank you for your attention & your participation in DCRC research

See DCRC website for further resources
http://www.dementiaresearch.org.au

Resources

Alzheimer’s Australia Help Sheets

Translating what we know about pain recognition & management in people with dementia

Dementia Outcomes Measurement Suite

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