

MANAGING BEHAVIORAL SYMPTOMS OF RESIDENTS WITH DEMENTIA IN LONG-TERM CARE FACILITIES

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MANAGING BEHAVIORAL SYMPTOMS OF RESIDENTS WITH DEMENTIA IN THE LONG-TERM CARE
SETTING

Dementia Education & Training Program
1-800-457-5679

INTRODUCTION

MANAGING BEHAVIORAL SYMPTOMS OF RESIDENTS WITH DEMENTIA IN LONG-TERM CARE FACILITIES

This book describes common behavioral problems encountered in demented patients who receive long-term care. This outline emphasizes proper assessments, behavioral interventions, and compliance with federal regulations. A second volume, *The Short Practical Guide for Psychotropic Medications*, provides more detailed explanation for prescription of psychotropic medications. This text can be used in conjunction with the DETA Brain Series for licensed professionals and the DETA Care Series for CNA's or personal care attendants.

All segments in this handbook are compliant with OBRA, i.e., federal, nursing home regulations. These management strategies are feasible in facilities with limited neuropsychiatric support services.

These guidelines are general outlines for behavior management. Each resident with behavioral problems must receive individual assessments and clinical plans designed by the treatment team.

SECTION 1

OBRA COMPLIANCE FOR BEHAVIORAL MANAGEMENT

Federal regulations on nursing home care mandate behavioral management for persons residing in nursing homes. Pharmacological interventions are reserved for those individuals who cannot be managed through behavioral interventions. The OBRA regulations specify that behaviors such as repetitive questions, harmless wandering, fidgetiness, etc., are not appropriate target symptoms for psychotropic medications.

A behavioral management program that complies with federal nursing home surveyor guidelines includes five components: 1) identification of problem behavior, 2) patient assessment, 3) specific systematic behavioral interventions, 4) documentation of outcomes for behavioral interventions, and 5) necessary adjustments of program based on observed results.

Documentation should include the clinical features, frequency, and duration of the targeted behavior, as well as consequences of behavior for other residents. The behavioral note that is entered in the resident's records should review medical, psychiatric, environmental, and cognitive antecedents for the behavior. The multidisciplinary assessment and intervention must include all involved disciplines, e.g., nursing, physician, recreational therapy, etc. The evaluation should reflect the severity of symptoms, the nature of the problem, and the type of intervention. For example, the use of restrictive behavioral management, such as constant monitoring or psychotropic medication, would warrant a detailed assessment, e.g., assessment for delirium, new medical problems, etc. The prescribed intervention must be communicated via the medical record to all appropriate staff members, e.g., redirect patient when he claims that he must go

SECTION 1

home to see his brother. Finally, the staff must document the efficacy of the behavioral intervention. The resident record must include an initial note that describes target symptoms and assessment; however, ongoing measurement of effectiveness for behavioral interventions require flow sheets, checklists, nursing notes, etc. Residents who fail specific behavioral interventions must have an alternative plan to deal with the behavior.

Federal nursing home guidelines promote a multidisciplinary approach for all behavioral problems. The facility must demonstrate communication between doctors, nurses, recreational therapists, or other individuals who are responsible for behavioral management. The nursing home medical director plays a pivotal role in assuring that all physicians participate in appropriate behavioral management programs or delegates this responsibility to the treating physician. The director of nursing must assure that all shifts are familiar with behavior management programs and that staff achieves adequate competency in behavioral interventions. The facility director must assure that the recreational programming person is coordinated with the nursing staff to assure that daily activities and recreational programming are made available for behavioral management purposes.

A smart behavior management program always includes family education. Staff should inform family about the problem behaviors and management strategies. Family education increases the likelihood that caregivers will agree to new treatment strategies, e.g., psychiatric consult or hospitalization, and proactive family education reduces the likelihood of complaints or litigation resulting from adverse outcomes, e.g., falls, injuries.

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SECTION 2

ORGANIZATIONAL STRATEGIES FOR THE MANAGEMENT OF RESIDENTS WITH BEHAVIORAL DISTURBANCES

INTRODUCTION

The long-term care management team must organize the behavioral management program. Management must devise appropriate procedures, educational programs, assessment strategies, and outcome documentation. Corporate leadership, management, staff, and family are participants in any behavior management strategy. All behavioral management programs for a resident must document the interventions and outcomes in the resident's record. The effect of any intervention should be recorded and reviewed on a regular basis. The treatment team should alter plans that fail to improve behavior and reassess the impact of the changed plan. Family caregivers should be informed about the behavioral problems, management strategies, and results of the intervention. Behavioral disturbances can be produced by problems with the resident, the staff, or the environment. The assessment of behavioral abnormalities requires a thorough assessment of the physical and mental health of a resident to determine whether new medical or psychiatric problems have occurred to produce the symptoms. Changes of the living environment or staffing can also change resident's behavior.

Staff and family must understand common cognitive, i.e., intellectual deficits associated with dementia. Many behavioral problems result from the caregiver's or staff's expectations that a resident can perform a task that the resident can no longer remember. Section 3, pages 10-11, outlines common intellectual deficits of dementia that must be understood by all staff and caregivers. The assessment of

any behavioral problem requires careful documentation of clinical features involved with the behavior. Staff or family should note frequency of

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episodes, duration of symptoms, and preceding events that precipitate the behavior as well as interventions that seem to lessen the symptom. Psychotic symptoms that produce behavioral problems must be documented in the record.

Staff or family must be as precise as possible in defining the specific features of the symptom, e.g., wandering versus resident walking in place or roaming. These symptoms should be recorded for use by the physician for pharmacological therapy.

Staffing changes can produce behavioral problems in residents. The loss of experienced staff increases the likelihood that confrontations occur with residents. Staff education about dementia is crucial to appropriate behavior management. Inadequate numbers of trained staff increases the likelihood that residents are not adequately reassured, fed, hydrated, or toileted.

The DETA Brain Series provides comprehensive education for licensed professionals about behavior management. The DETA Care Series translates these principles for non-licensed staff with limited experience in dementia. Staff must distinguish behavioral problems arising from intellectual deficits from behavioral problems produced by psychiatric symptoms, e.g., hallucinations or delusions. Psychiatric symptoms can be treated with psychotropic medications under federal nursing home regulations. Behavioral problems arising from cognitive deficits require behavioral management unless symptoms are a significant risk of harm to resident, staff or others.

The therapeutic environment can effect the resident's behavior. Chaotic, noisy environments can precipitate many behavioral problems in demented residents.

SEGMENT 2

Environmental changes, e.g., crowding, noise, poor lighting, and unpleasant odors, can agitate residents. The behavioral symptoms, e.g., a roommate who screams or rummages, may worsen behavioral problems in the "agitated" resident. Even simple environmental changes can distress a demented patient, e.g., changing a resident's room. A calm, quiet, structured, predictable therapeutic environment is best for demented residents.

This module contains several sections, including a checklist of common behaviors with basic interventions that are appropriate to reduce the likelihood of resident distress or use of psychotropic medications. Management strategies for dangerous problems like falls and weight loss are described because many behavioral problems worsen these complications. Staff and caregiver educational resources are listed for utilization. Specific troublesome behaviors such as aggression, sexual behavior, wandering, etc., are discussed at length. The final segment discusses OBRA compliance for nursing home staff.

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SECTION 3

BEHAVIORAL CONSEQUENCES OF COGNITIVE IMPAIRMENT

Amnesia: *The inability to remember recent or remote facts.*

The human brain stores two types of memory -- recent and remote. Recent memory is stored for brief periods of time (e.g., 20 minutes - 2 hours) and is then erased or placed into long-term storage. During the course of an average day, a normal person will remember many small details that are not committed to long-term memory (e.g., location of a car in the parking lot, lunchtime, location of purse or briefcase, location of medications or slippers, etc.). Long-term (remote) memory stores images and facts from months or years ago that are of great importance or emotional value to the person. Alzheimer's residents lose recent memory first and retain remote memory until later in the disease. Residents live in the past because they cannot remember the present. Memory problems produce common symptoms like repetitive questions, disorientation, and failure to follow directions, among others.

Aphasia: *The inability to understand spoken or written words or the inability to speak or write for the purpose of communication*

One brain region controls speaking, i.e., the frontal lobes, and a second brain region controls understanding, i.e., the temporal lobes. It is possible to speak but not understand spoken words. Residents with Alzheimer's disease frequently have difficulty understanding spoken words and struggle to find the word that they want to say. Aphasic residents act as if they understand when they do not. Many residents can repeat words that they do not understand. This causes staff or family

to believe they understand instructions but refuse to comply with requests. Dementia residents become frustrated as they struggle to find the right word.

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Communication deficits often produce problems with following directions or redirecting, e.g., resistiveness.

Apraxia: Inability to do pre-programmed motor tasks.

Complicated learned motor skills like shaving, tooth brushing, dressing, driving the car, eating, and walking are stored in discrete brain regions. These stored skills are erased by dementia. The residents have normal strength in their arms and legs because the nerves and muscles continue to function properly. Alzheimer residents do not become paralyzed -- they simply forget how to use their limbs to perform learned tasks. Apraxia can produce common problems like refusing ADL's, incontinence, falls, and weight loss.

Agnosia: The inability to recognize previously learned sensory input, e.g., faces.

The human brain stores images of faces, objects, animals, plants, etc. and compares what you see to what you know. The disease erases these stored images. Residents also lose the recognition of touch and smell. Residents may forget the shape of toilets, water bottles, clothing, or people. These residents do not identify family and staff properly or misidentify them as someone else. Agnosia can produce resistiveness, incontinence, or dehydration.

SECTION 4

ASSESSMENT OF AGITATION IN THE LONG-TERM CARE RESIDENT

Agitation is a frequent symptom in nursing home residents that occurs in 75% of demented residents. Agitation is a vague clinical term indicating motor or verbal activity not explained by the resident's needs or situation. Dementia is the permanent loss of multiple intellectual functions. Amnesia (memory impairment), aphasia (communication problems) and apraxia (inability to perform complicated motor tasks) are common cognitive symptoms of dementia. Agitation can be verbal, e.g., screaming, or physical, e.g., wandering, hostility, etc. Staff will frequently misinterpret symptoms of cognitive impairment as agitation (e.g., repetitive question asking, struggling during ADL, pacing, etc.). Distressed, loud or combative residents should be carefully evaluated prior to use of sedatives. Residents become agitated for a variety of reasons including pain, hunger, fear, boredom, fatigue, environmental chaos and as a consequence of medications or medical problems (i.e., delirium). Staff should carefully document the time, duration, frequency, severity and special features of agitation.

PAIN:

Chronic, persistent pain is common in nursing home residents and approximately 25% will require some form of continuous analgesic therapy. Few residents receive consistent adequate medication to control pain. Extremity and joint pain are common as well as visceral distress. Oral problems such as malfitting dentures or carious teeth will cause agitation during eating. Demented, aphasic residents lose the ability to explain physical pain or request pain medications. Rectal impaction and constipation are extremely uncomfortable for cognitively intact

individuals and may provoke agitation in dementia residents. Gastroesophageal reflux disease (GERD), gastric ulcer pain and angina can go unrecognized in

SECTION 4

demented residents. The nursing staff should conduct a thorough review of physical conditions to determine whether a resident needs antacids, analgesics, laxatives or nitrates to lessen pain and “agitation”. Chronic neuropathic pain from diabetes or limb amputations may improve with prescription of anticonvulsants, e.g., tegretol, neurontin. Severely demented residents may not be able to accurately localize pain and staff should not depend on residents to localize areas that hurt them. Amnesic residents may forget they experienced pain (e.g., angina) after a short interval. Physicians should not depend on the self-reporting of demented patients to adjust analgesic medications. Further discussion of pain management is available in the chapter entitled “*Management of Pain in Persons with Dementia*” Section 11 in booklet [A Short Practical Guide for Psychotropic Medications in Dementia Patients.](#)

HUNGER:

Hunger is a common cause of agitation in the dementia resident. Residents who eat part of their meals and remain physically active can become hungry. Alzheimer residents lose weight even with good nutrition. Staff should consider offering snacks to residents who become restless one or two hours following meals. Strict diabetic calorie control is not worth the use of medications to control behaviors caused by hunger. Diabetic Alzheimer residents may benefit from less stringent glucose control to prevent hypoglycemic episodes and resident hunger. Dehydration and thirst are also important causes of agitation. Residents should be prompted to take fluids every two hours to avoid becoming dehydrated, irritable and constipated. Staff must physically assist demented residents to drink fluids.

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FEAR:

Dementia victims are often afraid. Alzheimer residents cannot remember the name of their facility, staff, or even themselves. This disorientation and lack of familiarity cause distress and fear. Reassurance and distraction are appropriate interventions for disoriented, fearful individuals. Verbal reassurance may have limited value in an aphasic resident and staff must utilize nonverbal communication (e.g., smiling, gentle touch, calm voice) to assure distressed residents that all is well.

BOREDOM:

Boredom is a major problem for nursing home residents. Recreational activities should consume as much resident time as possible. Television talk shows are not entertaining for aphasic dementia residents. Recreational therapy staff must develop daily activity programs that entertain and engage resident with limited memory, communication skills and motor skills. Behavioral symptoms are more common in late stage Alzheimer residents (i.e., stage 4 and 5) who have multiple cognitive deficits that impair their ability to participate in recreational activities.

DELIRIUM:

Abrupt onset of agitation is frequently produced by delirium. Such residents require careful evaluation to determine medical causes of confusion. Urinary tract infections, pneumonia, colicystitis and other infections can cause acute confusion. New medications such as antihistamines, benzodiazepines and narcotics, e.g., demerol, can also cause residents to be confused and agitated (**See Delirium Fact Sheet on Page 22**).

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MEDICATION SIDE EFFECT:

Residents may appear agitated as a consequence of neuroleptic medications. Most old antipsychotics, e.g., Haldol, and some medical drugs such as Reglan and Propulsid can cause akathisia. Akathisia is an inner sense of restlessness and motor activity caused by dopamine blocking agents. These residents will often pace the halls, fail to sit still and appear quite restless. Increasing antipsychotics for this type of “agitation” will worsen symptoms. Appropriate interventions include neuroleptic dose reductions, inderal and low-dose benzodiazepines (*See A Short Practical Guide for Psychotropic Medications in Dementia Patients Handbook*).

PSYCHIATRIC SYMPTOMS:

Psychosis and depression are common problems in persons with dementia. Hallucinations and delusions can produce distress and fear. Demented residents may be unable or unwilling to describe symptoms of psychosis or depression to staff. Both psychosis and depression are improved with appropriate psychopharmacology (*See Depression Fact Sheet on Page 20, and Psychosis Fact Sheet on Page 21*).

UNMET ADL NEEDS:

Residents may become agitated when they are wet, cold, hot, or need to toilet. Staff should check room temperature, clothing, and need to toilet during periods of agitation. Mid-stage and end-stage

dementia patients usually lack the ability to explain discomfort produced by soiled clothing.

ENVIRONMENT:

Environment can provoke agitation in some dementia residents. Noisy, chaotic units cause dementia residents to become restless. Crowded, noisy day rooms can

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make residents fearful and restless. Hostile or loud roommates who disrupt sleep patterns can cause residents to become irritable.

CONCLUSION

The “agitated” dementia residents presents a special diagnostic challenge to the long-term care management’s team. Many types of agitation are worsened by sedatives and antipsychotics. Prior to the use of these medications, staff should consider pain, hunger, fear, boredom, delirium and medication side effects as possible etiologies. Residents who become agitated in response to hallucinations, delusions or depression warrant a careful trial with psychotropic medications. Depressed residents should be treated with antidepressant medications.

Appropriate documentation for agitation include a precise description of symptoms, i.e., frequency and severity. Clinicians must identify the cause and consider behavioral interventions prior to using medications or restraints.

BEHAVIORAL CHECKLIST FOR DEMENTIA RESIDENTS

SYMPTOMS	CAUSES	INTERVENTIONS / TREATMENT
(1) Wandering	Disorientation	See Recreational Activities Fact Sheet on Page 24
	Thirst	See Wandering Handout on Page 35 See Dehydration Fact Sheet on Page 23
(2) Yelling		See Screaming Handout on Page 49 See Recreational Activities Fact Sheet on Page 24
	Thirst	See Dehydration Fact Sheet on Page 23
(3) Verbal or Physical Threats	Fear	Reassurance
	Disorientation	Reorientation and Reassurance
	Fatigue	Naps
	Hunger	Feed Resident
	Thirst	See Dehydration Fact Sheet on Page 23
	Pain	Analgesics (See Pain Handout on Page 19)
	Delusion	See Psychosis Fact Sheet on Page 21
	Aphasia	Non-verbal Communication
	Rectal Impaction	Remove Impaction
	Delirium	See Delirium Fact Sheet on Page 22
Sensory Impairment	Check Vision and Hearing	
4. Aggression		See Aggression Handout on Pages 55-56
5. Sexually Inappropriate Behavior		See Abnormal Sexual Behavior Handout on Page 45
6. Incontinence		See Incontinence Handout on Page 68
7. Stealing	Disorientation	See Recreational Activities Fact Sheet on Page 24
	Delusions	See Psychosis Fact Sheet on Page 21
8. Disrobing	Amnesia	See Recreational Activities Fact Sheet on Page 24
	Apraxia	Jumpsuits
	Anxiety	See Recreational Activities Fact Sheet on Page 24
	Delirium	See Delirium Fact Sheet on Page 22

MANAGING BEHAVIORAL SYMPTOMS OF RESIDENTS WITH DEMENTIA IN THE LONG-TERM CARE SETTING

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BEHAVIORAL CHECKLIST FOR DEMENTIA RESIDENTS *(continued)*

SYMPTOMS	CAUSES	INTERVENTIONS / TREATMENT
(9.) Weight Loss		See Weight Loss Handout on Pages 69-73
(10.) Agitation		See Agitation Handout on Pages 12-16
(11.) Repetitive Questions	Amnesia Boredom Aphasia	See Recreational Activities Fact Sheet on Page 24 See Recreational Activities Fact Sheet on Page 24 Non-Verbal Communication
(12.) Poor Hygiene	Apraxia Aphasia Psychosis	See Bathing Handout on Pages 80-83 Non-Verbal Communication See Psychosis Fact Sheet on Page 21
(13.) Falls		See Falls Handout and Falls Fact Sheet on Pages 74-79
(14.) Misidentification of Caregiver	Agnosia Delusions	Tolerance See Psychosis Fact Sheet on Page 21
(15.) Sundowning		See Sundowning Handout and Sundowning Fact Sheet on Pages 58-62

FACT SHEET ON PAIN MANAGEMENT FOR DEMENTED PATIENTS

1. Chronic pain is common in nursing home residents with dementia.
2. Patients with dementia may manifest pain through behavioral changes.
3. Effective pain management begins with a careful clinical evaluation and treatment that is specific to the cause and type of pain.
4. Pain management involves physical, psychological, and pharmacological therapy.
5. Neuropathic pain produced by damage to pain sensing organs, nerves, or spinal cord is best treated with anticonvulsants, e.g., tegretol, neurontin.
6. Phantom limb pain that follows amputation of extremities is best treated with anticonvulsants, e.g., tegretol.
7. The best treatment of pain associated with inflammation, e.g., arthritis, is physical therapy and antiinflammatory medication.
8. Pain associated with fractures from osteoporosis can be treated with calcitonin.
9. Nociceptive pain is produced by damage to tissue or organs and frequently require analgesic therapy.
10. A regular dose of acetaminophen is the first pharmacological intervention for nociceptive pain.
11. Non-narcotic medications are effective for nociceptive pain, e.g., tramadol.
12. Patients who require narcotic analgesics for chronic pain should receive regular scheduled doses.
13. Propoxyphene, i.e., Darvon, has the same pain-relieving effect as acetaminophen.
14. Some medications work by producing euphoria and confusion, rather than analgesia or pain relief, e.g., Demerol, Talwin, Darvon.
15. Patients who fail a combination of physical, psychological, and pharmacological interventions, should be referred to pain clinics for further evaluation and management.

**For more information or inquiries, call the Dementia Education & Training Program at
1-800-457-5679.**

FACT SHEET ON DEPRESSION IN THE ELDERLY

1. Depression is a biological brain disorder.
2. Depression is not a normal part of aging.
3. Depression is treatable.
4. Seven to 12 percent of all people over the age of 65 become depressed.
5. Suicide is one of the 10 leading causes of death in the elderly.
6. Thirty to 40 percent of all seriously medically ill elderly individuals suffer from depression.
7. Most depressed residents cannot make themselves well.
8. Seventy to 90 percent of depressed elderly residents will improve with medication and other therapy.
9. Most elderly depressed residents can be treated as an outpatient.
10. Many medications such as antihypertensives cause or worsen depression.
11. Some depressed elderly individuals need three or four types of antidepressant therapy before they improve.

FACT SHEET ON PSYCHOSIS

1. Hallucinations and delusions are common in dementia.
2. Auditory hallucinations are when residents hear voices or sounds when none exist.
3. Visual hallucinations are when residents see animals, people or images when nothing is there.
4. Auditory or visual impairment worsens hallucinations.
5. Hallucinations are caused by brain regions misfiring and the resident cannot distinguish misconceptions from reality.
6. Delusions are fixed false beliefs with no basis in fact.
7. Many dementia residents have delusions.
8. Delusions frequently cause residents to accuse family or caregivers of misconduct.
9. Delusions are not a reflection of past beliefs.
10. Residents can be terrified by hallucinations and delusions.
11. Antipsychotic medications improve hallucinations and delusions.
12. Arguing or reasoning with psychotic residents doesn't help.
13. Ignore hallucinations or delusions, distract the resident, and focus on pleasant topics.
14. Some delusions and hallucinations are quite convincing, but all come from brain malfunction.

FACT SHEET ON DELIRIUM IN THE ELDERLY

1. Delirium is temporary confusion or intellectual impairment from medical problems.
2. Delirium is reversible and common in the elderly.
3. Delirium is frequently caused by medications such as sleeping and nerve pills, or over-the-counter medications (e.g., antihistamines or cold preparations).
4. Delirium is very common in brain damaged individuals like Alzheimer or stroke residents.
5. Major problems like strokes, pneumonia or major surgery can cause delirium.
6. Minor problems like fecal impaction and bladder infection can cause delirium.
7. Delirious residents can become hostile or agitated.
8. Delirious residents often develop psychiatric symptoms.
9. Delirium is easy to treat - simply fix the medical problem or stop the drug. Delirious residents get better when appropriately treated.
10. Delirious residents frequently do not get better because the delirium is unrecognized.
11. Residents who remain delirious have a higher risk for serious complications.

FACT SHEET ON HYDRATION

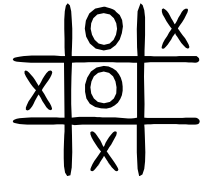
1. Alzheimer's patients need about 6 medium-sized glasses of water per day.
2. Any food or liquid that includes water helps with hydration, e.g., jello, pudding, milk, etc.
3. Dehydration is lack of sufficient fluid.
4. Poor fluid intake produces confusion, agitation, and infections.
5. Poor fluid intake results in hospitalization of older persons.
6. Residents with mild to moderate dementia forget where water is located.
7. Moderate to severely demented patients forget how to pour a cup and drink from a straw.
8. Severely demented patients may choke on liquids.
9. Poor fluid intake causes irregular bowels or rectal impaction.
10. Workers must regularly help Alzheimer's patients drink fluids to assure adequate hydration.

ACTIVITY IDEAS

From A to Z



- A. Converse with a resident.
- B. Help a resident with a lacing project.
- C. Initiate a group parachute game or ball toss.
- D. Play a word game with 2-3 residents.
- E. Initiate a discussion group on a subject that rekindles fond memories.
- F. Lead a sing-a-long.
- G. Talk with a resident about an old photograph.
- H. Play a game of ring-toss with several residents.
- I. Have a resident identify various scents.
- J. Play a game of balloon volleyball.
- K. Play a familiar music tape and have residents "name that tune."
- L. Give a resident a hand massage.
- M. Initiate a similes word game (i.e. as fresh as a _____).
- N. Play a game of adapted bingo where participants cover pictures instead of numbers.
- O. Allow a cognitively impaired resident to unravel yarn.
- P. Cut pictures into simple shapes and have a resident put them together.
- Q. Play a bean-bag toss game.
- R. Present items of different textures and have resident describe feel.
- S. Read a newspaper story to alert resident with visual impairment.
- T. Arrange residents in circle and have a game of kick-ball.
- U. Have a group discussion on old cars, favorite dinner or movie.
- V. Have a resident match colors using color cards.
- W. Dance with a resident.
- X. From a chair, lead residents through various stretches.
- Y. Have residents pass a ball to each other while in circle.
- Z. Use your own ideas – Adapt to level or resident.



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ASSESSMENT AND MANAGEMENT OF THE WANDERING RESIDENT

The wandering resident is a problem both in the home and the nursing home. Wandering behaviors will occur in 25-50% of demented residents and this symptom is most common in the middle stage of dementia. Wandering is important because this behavior may produce elopements, injuries, or patient-on-patient aggression.

Wandering can be divided into several categories including 1) residents who attempt to escape, 2) residents who rummage, 3) residents who roam through the unit or the home, and 4) residents who visit. The treatment of wandering behavior begins with a careful assessment of the problem. The family or treatment team should carefully monitor the resident's behavior over a 7-10-day period, during which there are no new medical problems or environmental changes. 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 resident's behavior. The treatment options for wandering behaviors are based on the causes and clinical features of this disruptive activity. While some residents 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. Residents 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 resident for several weeks after admission to determine his baseline level of activity. Residents who begin to wander after a prolonged period of stability in a

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facility suffer from some new complication – medical, psychiatric or cognitive. Delirium may produce the abrupt onset of wandering behavior. Delirious residents may seem more confused and these individuals are at risk for falls or injury. The staff should observe when the resident begins to wander during the day to assess whether environmental stimulation such as other yelling residents or chaos on the unit precipitates the behavior. All wandering residents 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 resident on the toilet as residents may have forgotten these skills. Food should be placed directly in the resident’s hands. Hydration should include placing a cup up to the resident’s lips.

For the resident who was newly admitted to the facility, the staff must determine the resident’s activity level prior to admission. Residents are likely to require exercise on a regular basis outside the facility if they were physically active prior to admission or they spent a great deal of time outdoors. Some residents will follow other wandering residents. Some wandering individuals will lead other residents by the hand. Treatment should focus on separating the residents and treating the wanderer. Residents who struggle during redirection should be assessed for aphasia and psychosis. Residents with impaired communication will require non-verbal communication for redirection.

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TYPES OF WANDERING

EXIT-ORS

Elopement is a serious event that can produce fatal injuries to patients, severe regulatory punishments, and lawsuits. Every elopement should be considered an emergency and facilities should have procedures to manage the loss of a resident.

Residents who attempt to flee the facility may be confused or psychotic. Confused residents are unable to orient themselves in the nursing home or assisted living facility and these individuals require constant reassurance and surveillance to maintain calm. Residents who are attempting to flee because of delusions or persecutory hallucinations are best treated with antipsychotic medications. The target symptoms for these medications are hallucinations or delusions—not wandering. For example, the resident who wants to leave because they must “go home and care for my babies”. Exitors should have safe-return identification and staff should regularly check for their locations. Residents who want to “go home” are rarely improved by visits to their last residence or ancestral home. Most residents will not recognize their home and they will attempt to flee their old residence as well. Anytime a resident elopes from a facility, the staff must immediately determine the cause and correct the security problem.

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

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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

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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 older, i.e., 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 newer, i.e., atypical antipsychotics, e.g., Olanzapine and Seroquel, have less tendency 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, e.g., COPD.

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 residents require specialized programming to accommodate their increased activity in the p.m. The goal is to keep these residents safe and out of other individuals' rooms who are attempting to sleep (**See Section on Sundowning on Pages 58-62**).

RUMMAGE-ORS

Rummaging behavior is less common than orbiting, but this symptom can produce chaos on a unit. The rummaging resident will enter another resident's room and search through drawers or closets. Disoriented residents may view other person's

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rooms as a shopping mall where they can “purchase” new clothing or personal items. Most residents rummage because they are bored and confused. Recreational activity can lessen this behavior and some units have specific “rummaging rooms” for these residents. Some residents rummage in specific rooms because of delusional beliefs, e.g., the rummager is married to the occupant. The delusional resident may improve with psychotropic medications; however, antipsychotic medications are not used for rummaging behavior unless there are specific delusional beliefs that produce the behavior.

VISIT-ORS

Some residents will wander through the unit and enter other resident’s rooms to socialize and visit. These residents 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 OF WANDERING

The treatment of the wandering dementia resident depends on the type and severity of this behavior. Some interventions may help all wandering residents, while other interventions are focused on very specific types of wandering. Staff education and staff vigilance are the most important components of wandering management. All staff, including office help, housekeepers, and dietary staff, should remain alert and report potential elopements to nursing staff.

One goal of therapy for all wandering residents is to prevent intrusion into other residents’ rooms. Large, colorful signs with the resident’s name that are individualized may help disoriented residents to identify their room. Similar signs should be placed over bathrooms.

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Specific boundary markers such as *stop signs* and *crosshatches* on the floor may lessen the likelihood that some residents attempt to leave. A wander-guard system, i.e., electronic warning system, is more effective and safer for these residents. The systematic assessment of wandering residents followed by behavioral, medical, and pharmacological interventions can reduce disruptive behaviors in most residents and assures unit safety. A very small group of residents persistently and aggressively wander. These individuals may become hostile during redirection and create chaos on the units. Such residents should be referred to specialists with expertise in geriatric psychiatry or behavioral neurology for a more detailed assessment and recommendations for psychotropic medications. Some residents will crawl into bed with other residents, 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 residents. 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 result 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 residents 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.

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Table 1

WARNING SIGNS FOR ELOPEMENT

1.	Door Checking
2.	Standing At Exits
3.	Watching Key Pad Codes

Table 2

ELOPEMENT PROCEDURES

1.	Check Security
2.	Perform Resident Count
3.	Organize and Initiate Search
4.	Call for Assistance or Law Enforcement as Needed

ELOPEMENT PREVENTION

Resident elopement occurs when a patient exits a facility without the knowledge or consent of staff. Some residents may demonstrate behaviors like door-checking or standing at exits (See Table 1). The first step in management of elopement is to retrieve the resident, assess for injuries, and inform family as well as regulatory agency (See Table 2). Staff should assure that other residents have not eloped via the same route. Once the individual is returned to the facility, the resident should be monitored until the situation is clarified. Staff should determine the route of

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departure and assure that other residents do not use this same route. Management should review all residents at risk for elopement within the facility, e.g., locking doors, monitoring residents, etc. **(See Elopement Handout on Page 36)**

CONCLUSION

Wandering is a common behavior in residents with mid-stage dementia. Long-term care providers should know basic facts about wandering **(See Wandering Fact Sheet on Page 35)**. Any elopement is a serious event that produces immediate jeopardy to the resident and liability for the facility. Management of the wandering resident begins with a thorough assessment and the treatment team should ask questions prior to initiation of therapy **(See 10 Questions That Nurses Should Answer About A Wandering Resident on Page 34)**. Treatment includes behavioral, medical and pharmacological interventions.

10 QUESTIONS THAT NURSES SHOULD ANSWER ABOUT A WANDERING RESIDENT

1. WHEN DID THE WANDERING BEGIN?

Resident may have been moved from one room to another and now he/she is disoriented. If it's a slow incremental increase in wandering, i.e., over weeks or months, then that's most likely secondary to the dementia.

2. WHEN DOES THE WANDERING OCCUR DURING THE DAY?

If resident wanders 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 RESIDENT AN ORBIT-OR, RUMMAGER-OR, EXIT-OR, OR VISIT-OR?

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

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

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

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

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

Did the resident 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 Pages 17 and 18).

8. DID YOU CONSULT THE RECREATIONAL THERAPIST?

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

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

Residents 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 RESIDENT'S CNA OR CAREGIVER BEEN CHANGED?

Poorly trained or inexperienced staff may stress or agitate residents through poor resident management that increases wandering.

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FACT SHEET ON WANDERING

1. Wandering is common in residents 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 residents 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 residents 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.

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NURSING HOME FACT SHEET ON **ELOPEMENT**

1. Elopement is a serious event that requires immediate action.
2. Elopement occurs when a resident escapes from the security zone in the facility.
3. The loss of one resident suggests that other residents may also be missing.
4. The first step to manage an elopement is organize a search of the building and adjacent grounds.
5. Wandering patients and persons with past elopements are at higher risks for escape.
6. Absence of a live-in caregiver, e.g., wife, may cause new wandering behavior or attempts at elopement.
7. Residents who elope from the facility should have an assessment when they return to the facility.
8. Staff should assure that all security measures are operational whenever a patient elopes.
9. Law enforcement should be notified when insufficient staff is available to search for a patient or the search of the facility and grounds fails to identify the missing resident.
10. A patient elopement must be reported to the surveyors and the supervisors for investigation and corrective actions.

SECTION 6

INAPPROPRIATE SEXUAL BEHAVIOR IN THE ALZHEIMER RESIDENT

Normal Sexuality in Elders:

Sexuality in the older resident with Alzheimer's disease is a complex issue that involves resident's rights and safety. Alzheimer victims who retain the ability to give informed consent for medical or legal decisions, i.e., very mildly demented patients, may decide to engage in sexual relations with persons of their own choosing. Persons with moderate to severe dementia rarely retain the ability to give informed consent for sexual activity. Older persons retain sexual drive through the 10th decade. The frequency of intercourse diminishes with age, beginning at age 50. Males and females both undergo physiological changes that may affect the pleasure and frequency of intercourse. Males usually have diminished drive, decreased ability to achieve erection, and higher rates of impotence. Females experience changes in vaginal lubrication and skin sensitivity in the perineal area related to alteration of estrogen levels. Although the drive and function of both males and females are diminished with aging, both groups may retain active sexual lives. Federal regulations require that competent, consenting nursing home residents have the opportunity to sustain an intimate, physical relationship. A competent, mildly demented resident has the right and the ability to sustain an appropriate, intimate relationship with another person. These behaviors fall into the category of normal sexual activity that does not warrant assessment or treatment.

A wide range of common clinical conditions that inhibit sexual function are present in the typical long-term care resident. Chronic alcohol abuse, diabetes

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mellitus, peripheral vascular disease, and many types of antihypertensive medications are known to produce sexual dysfunction in males. The likelihood that a chronically medically ill male sustains a vibrant sexual function while receiving multiple medications is quite small.

Abnormal Sexual Behavior:

Abnormal sexual behavior in the long-term care setting includes unwanted sexual advances, aberrant sexual behavior, e.g., public masturbation, and sexual aggression in brain-damaged individuals. The first step in assessing “abnormal sexual behavior” is to specify the type of abnormal behavior, frequency of occurrence, duration of the symptoms, and settings that produce the symptoms. The treatment team must examine both “the aggressor” and the person who is the target of the symptoms. The team must determine whether both parties were able to give consent based on cognitive and psychiatric status. The team must then determine the relative threat level of “the aggressor” based on the circumstances and actions. Allegations of coercion, physical assault or harm require close supervision of the accused individual, e.g., one-to-one observation, until the situation is clarified. The treatment team must gather specific details about the incident and examine past history to assess predisposition towards dangerous, sexually aggressive behavior. Although the allegation of a sexual offense can be a criminal matter in the nursing home, most law enforcement is reluctant to conduct a criminal investigation limited to nursing home residents.

Residents with past histories as sex offenders continue to pose a credible threat into late life. No present scientific evidence indicates that sex offenders, e.g., pedophiles, sexual predators, etc., are diminished risks in the long-term care setting. Pedophiles may target helpless individuals, e.g., mentally retarded persons, individuals with dementia. The diagnosis of sex offender or sexual

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predator requires a well-documented long-term history of criminal or sexually aggressive behavior that pre-dates the dementia or brain damage by many years.

Disrobing, Exhibitionism, And Public Masturbation:

Some patients remove clothing and wander throughout the facility. Some males may demonstrate evidence sexual arousal during this process. This public loss of personal privacy is demeaning to the patient and disruptive to the staff as well as other residents and visiting family members. Jumpsuits and reverse jumpsuits are effective interventions for demented residents who no longer remember how to maintain proper dress. Jumpsuits and reverse jumpsuits are no more restrictive than belts, shoes, suspenders, or helmets for residents who forget how to unfasten these items. Moderate to severely demented residents often forget how to remove belts, suspenders, lace shoes, and helmets and as such these items could be considered restraints. Some demented residents may learn how to remove jumpsuits or reverse jumpsuits. Consequently, the jumpsuit is not necessarily a restraint.

The use of a jumpsuit does not require a physician's order, i.e., as opposed to a restraint, but this nursing intervention does require an explanation in the nursing section of the resident's record. Any resident placed in a jumpsuit or a reverse jumpsuit must have a careful evaluation to exclude other treatable causes of the targeted behavior. When other treatment options have been excluded, i.e., toileting schedule, dis-impaction, recreational therapy, etc. then the reverse jumpsuits can be employed. All patients placed in reverse jumpsuits must be toileted every two hours and whenever they request access to toileting facilities. The jumpsuits

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should not be used for more than six months without a careful reconsideration of this treatment modality. After six months patients can be placed on a trial period of routine dressing to determine whether they can now tolerate standard clothing.

Alzheimer patients rarely develop other abnormal sexual behaviors, e.g. peeping, cross-dressing, and demented residents will not express new homosexual behaviors. Continuous masturbatory behavior is uncommon among Alzheimer's patients. Some manic patients and those with mental retardation may demonstrate repetitive masturbation during periods of mental illness, i.e., mania. These behaviors should be carefully evaluated for psychiatric or medical causes.

Many behaviors related to dementia can be mistaken for sexually inappropriate behavior. Most disrobed, wandering residents are not demonstrating exhibitionist behavior, but rather these confused individuals do not remember to clothe appropriately. Residents who manipulate their genital area may suffer from urinary tract infections, rectal impaction, yeast or vaginal infections, and multiple other disorders related to the genito-urinary tract or the perineal area. Any resident who is manipulating their perineal area should have a careful examination to exclude physical problems that would produce discomfort in this region. Manipulation of the genital area is more commonly associated with physical problems or unmet physical needs than with sexually driven behavior. Climbing into bed with other residents is rarely a sign of sexual aggression in a moderate to severely demented resident. Disoriented Alzheimer residents frequently lay in bed with other persons; however, this results from disorientation rather than amorous desires. Many Alzheimer residents with visual agnosias may not recognize other human beings as persons and these residents fail to understand the significance of their behavior. The resident who disrobes may be managed with reverse jumpsuits.

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The person who climbs into bed with other residents needs monitoring, redirection, and recreational programming to maintain a structured environment.

Sexually Aggressive Behavior:

Sexually aggressive behavior may include touching, fondling, or actual attempts at intercourse. Sexually inappropriate comments do not necessarily represent an intent towards sexually aggressive behavior, as some patients may not comprehend the meaning of their own spoken words, e.g., expressive aphasia. Several resident groups, e.g., demented resident with frontal lobe injury, individuals with isolated frontal lobe lesions, bipolar residents in the manic state, and delirious residents, may express inappropriate sexual ideas that do not indicate an intent towards sexual aggression. Sexuality is a biologically driven behavior that involves multiple brain regions. Consequently, there is no specific type or location of brain lesion that produces abnormal sexual behavior. Certain medications may produce hyper or hypo-sexuality. Medications that induce manic-like symptoms, e.g., steroids, antidepressants, may produce a flirtatious behavior on the part of residents. Medications for Parkinson's disease, e.g., L-dopa can produce significantly increased libido or abnormal sexual behavior that is typically seen in males.

Inappropriate sexual behavior in the demented resident can be difficult to assess because the resident may not be able to explain his/her actions. Most sexually aggressive behavior occurs in the mid or late stages of Alzheimer's disease. Other types of dementia, such as fronto-temporal dementia may produce sexual symptoms early in the disease.

A small group of demented residents demonstrate true, sexually aggressive behaviors. This may include touching or actual attempts at intercourse. Although

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the overall likelihood is low that a demented male could achieve adequate erection to initiate intercourse, Alzheimer's disease does not eliminate a male's ability to complete sexual intercourse. Female residents with dementia are very unlikely to sexually assault a male for multiple reasons; however, the possibility does exist that a female could engage in sexually aggressive behaviors. Alzheimer's disease very rarely produces homosexual behavior unless the resident was homosexual prior to dementia.

Treatment of Abnormal Sexual Behavior:

The first step in treatment of the sexually aggressive resident is the completion of a risk assessment for potential injury to resident, staff, or other residents. Residents at high risk for harming others, e.g., sexual behavior with physical aggression or harm, should be transferred to an inpatient geriatric psychiatry unit for stabilization. Individuals who demonstrate bothersome but non-harmful behaviors can be assessed on the unit. The team must document whether the resident demonstrates abnormal sexual behavior towards him/herself or towards others and whether the actions involve verbal or physical activities. The treatment team must determine whether the behavior is true, sexually driven activity or pseudo-sexual behavior masquerading as sexual aggression. Examples of pseudo-sexual behavior include disrobing, manipulation of the perineal area, climbing into bed with other residents, and using sexually expletives that have no discernible meaning to the resident. The pseudo-sexual behavior should be managed as any other behavioral problem. The optimum intervention is behavioral management that includes redirection, monitoring, and structured activities that prevent contact. Bored, wandering residents are at higher risk for disruptive behaviors. Moderate to severely demented residents can be placed in reversed jumpsuits to prevent

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disrobing, self-manipulation, or masturbation. If the treatment team determines that the behavior has true sexual intent, the resident's history must be reviewed for a past history of "paraphilic behavior". Paraphilic behaviors include a broad range of abnormal sexual behavior including pedophilia, voyeurism, cross-dressing, etc. Residents with a past history as sex offenders or as paraphilic disorders should be referred to a specialty unit for hospitalization and assessment. Residents without a past history of paraphilic behavior should be assessed for psychiatric causes of aggression.

A variety of pharmacological interventions may suppress sexually aggressive behavior. The treatment team must determine whether the resident manifests delusional ideas, e.g., the victim is a spouse. Delusions are treated with antipsychotic medications, e.g., olanzapine, seroquel. A variety of therapeutic interventions are available for demented residents with sexually aggressive behavior. A variety of pharmacological agents may diminish behaviors through sedation or diminished sexual drive. The antipsychotic, quetiapine (seroquel), is reported to reduce sexually aggressive behavior and most residents are treated with an antipsychotic as the first line of care. The efficacy of antipsychotic medications for sexually aggressive behavior is unclear. The serotonin reuptake inhibitors have been used to suppress sexually aggressive behaviors. SSRI's may increase or decrease libido but almost all medications in this class will reduce sexual function, i.e., induce erectile dysfunction in males. No specific type of SSRI has been demonstrated to be more effective. Residents with manic-like symptoms may benefit from mood stabilizers, such as tegretol, valproic acid or lithium. Mania is an unusual cause of sexually aggressive behavior in demented residents. In the

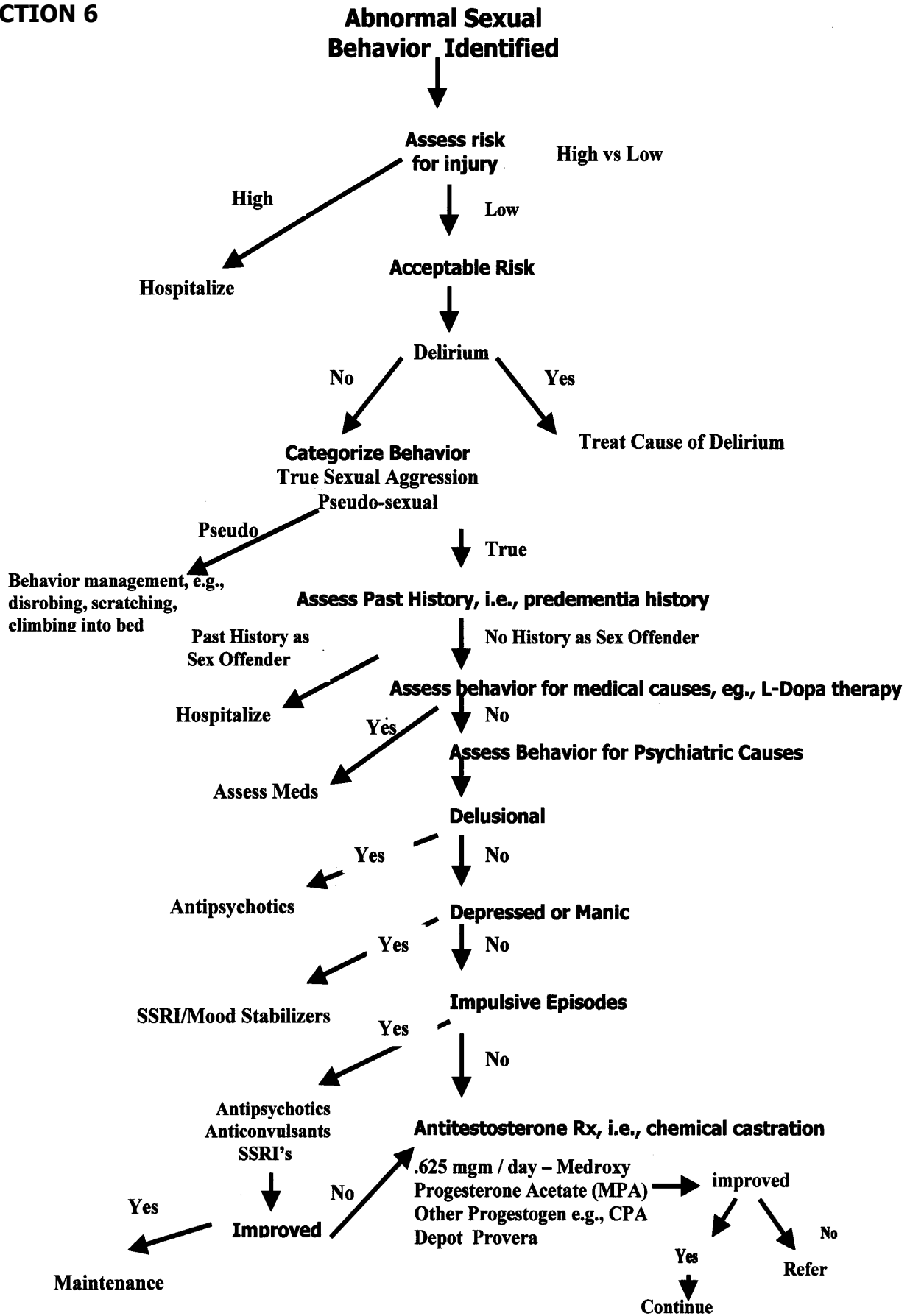
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absence of mood or thought disorders, the treatment team should determine whether the behavior is impulsive. Persons with pervasively impulsive sexual behavior may require antitestosterone therapy, sometimes referred to as chemical castration. In males, estrogen .625mgm per day has been used as well as progesterone such as medroxy progesterone acetate. These compounds can also be used with impulsive individuals who fail to respond to standard therapy. The use of chemical castration in the elderly dementia resident produces a complex mixture of legal, ethical, and pharmacological issues that are best managed by a geriatric psychiatrist.

SUMMARY

Abnormal sexual behavior in the long-term resident constitutes a diagnostic, therapeutic, and resident's rights dilemma for the treatment team. The assessment requires a multi-disciplinary approach to establish the competence of both participants and then determine whether the behavior constitutes true sexual aggression (**See diagram on page 45**). The clinical team must then document the nature of behavior and complete a careful clinical assessment of the aggressive resident. Behavioral interventions should be employed to diminish aggression; however, pharmacological management may be employed in selected cases. Difficult or dangerous residents should be referred to a specialist for further assessment and management. Most "sexual" behaviors in Alzheimer residents will result from non-sexual problems. The likelihood that a moderate or severely demented resident can successfully accomplish sexual intercourse is low; however, reasonable precautions should be used to protect other residents and the resident.

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SCREAMING BEHAVIOR

Screaming behavior is often referred to as disruptive vocalization, yelling, or hollering. Many Alzheimer's residents will cry out for no observable reason. Some hearing impaired demented residents speak loudly because they lose the ability to modulate the volume of their voice. Speaking loudly is distinct from disruptive vocalization – a recognized behavioral disturbance. Most screaming residents can be heard within 50 feet, i.e., the average radius of a dayroom. Studies on screaming residents indicate that they are more likely to be demented, have more ADL impairments and receive psychotropic medications. The life expectancy of a screaming resident is typically shorter than quiet individuals. Screaming behaviors can provoke assaults by other demented residents. Many screaming residents are ignored or isolated because their behaviors are so disruptive.

The treatment of a screaming resident begins with proper assessment of that individual. The basic assessment for screaming residents is similar to that of any agitated resident, i.e., assessment for pain, fear, hunger, thirst, and boredom (**See Pages 17-18**). Abrupt onset screaming behavior suggests new medical problems or delirium. Depression can produce screaming behavior in a demented resident and this symptom may warrant a six-week trial of appropriate doses of antidepressant medications, i.e., serotonin reuptake inhibitors, to determine whether the behavior is produced by depression. Psychotic fear can sometimes precipitate screaming in residents who are terrified by hallucinations or delusions.

Psychosis is treated with administration of antipsychotic medications. Some screaming residents may have chronic, under-diagnosed pain. Residents with

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diabetes, past alcoholism, or peripheral vascular disease may have chronic pain syndromes associated with peripheral neuropathy, i.e., neuropathic pain. Residents with amputated limbs, e.g., limb removal for vascular disease, experience discomfort where the limb was previously located, i.e., phantom limb pain. These residents can be treated with an anticonvulsant, such as Tegretol, to suppress both neuropathic pain and phantom limb. Osteoporosis often produces pain from fractures. Residents with bonified causes of pain, e.g., metastatic disease, past vertebral fractures, should be treated with appropriate doses of analgesics. Episodic pain may be produced by angina in residents unable to ask for nitroglycerine tablets. Screaming associated with diaphoresis may suggest angina.

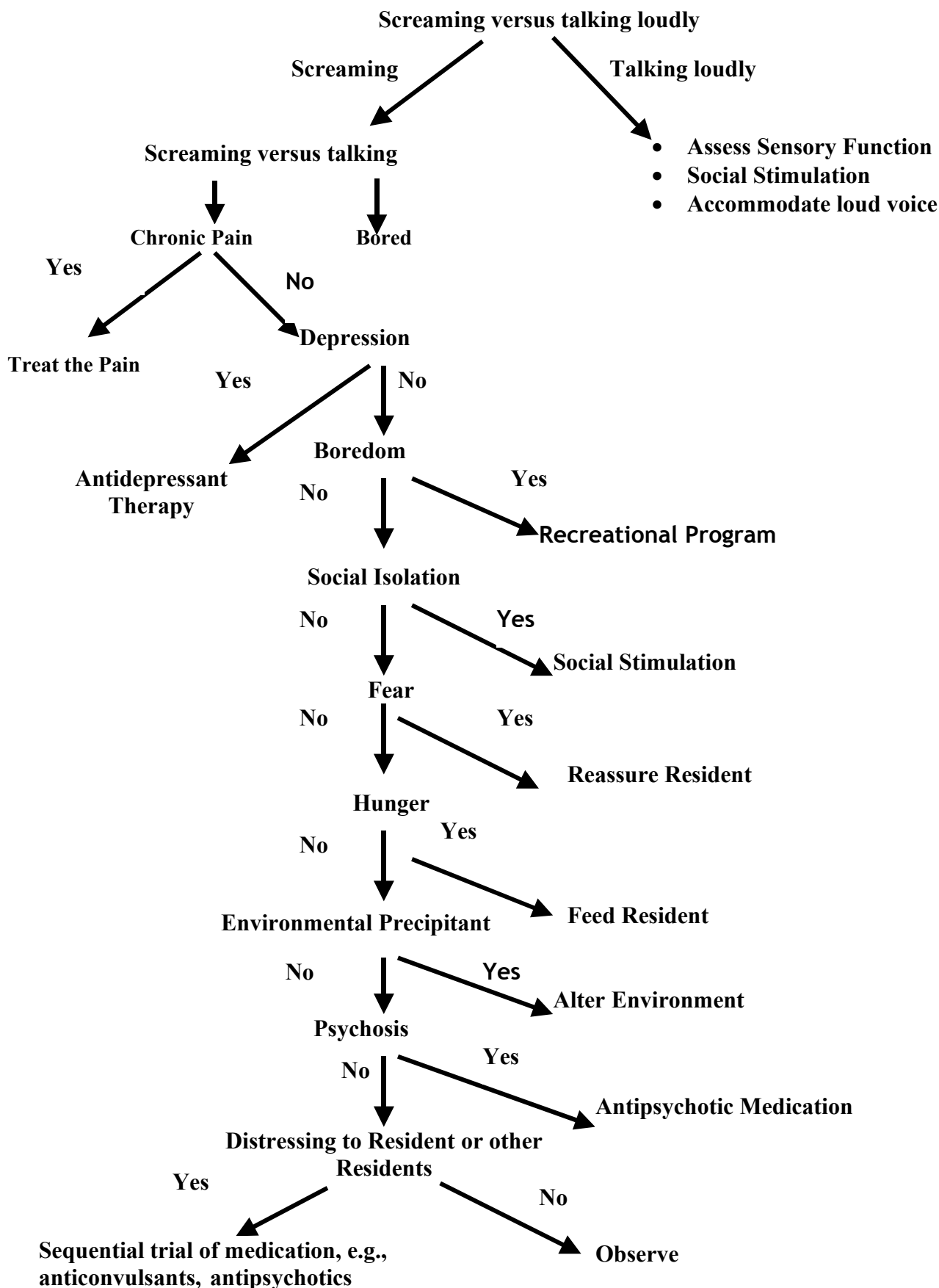
The assessment of screaming behavior should follow a systematic, comprehensive approach (**See Page 49**). The treatment of screaming begins with a thorough physical, mental, and social assessment. The screaming behavior can be divided into talkers versus screamers. Talkers are individuals who speak loudly for prolonged periods of time. These demented individuals are often bored or socially isolated and this behavior responds to environmental interventions, e.g., social stimulation, recreational programs, etc. Residents who scream loudly should be assessed as to whether they scream intermittently or continuously. Intermittent screaming behavior suggests some type of pain or situational problem, e.g., hunger, incontinence, etc. Residents who scream continuously suggests some other problem, e.g., depression, chronic unremitting pain, psychotic fear. In mild to moderately demented residents, the clinician may be able to determine the cause of the symptoms based on discussion with the resident. However, the clinician may be required to treat the severely demented resident empirically. The

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psychosocial management of screaming behaviors includes increased social stimulation, control of environment, e.g., avoid loud, disruptive environments, and meticulous nursing care to minimize precipitants such as soiled diapers, hunger, discomfort from continued positioning, etc. Residents who fail to respond to all forms of treatment should be referred to a geriatric psychiatrist or other specialist for further assessment and management.

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SCREAMING



SECTION 8

MANAGEMENT OF AGGRESSIVE BEHAVIOR IN THE NURSING HOME

Causes of Aggression

Verbal or physical aggression is common (about 25%) in middle or late stage dementia. Staff is the most common target of aggression (70%) and episodes occur most often during staff-patient interactions, e.g., ADL assistance. Management of aggression in the nursing home requires careful assessment and methodical treatment to assure maximum safety for residents, nursing home residents and staff. Aggressive symptoms can be verbal, physical or sexual. Severe physical and sexual aggressive behavior may require immediate, intense therapy. The extensive differential diagnosis for aggression in the elderly resident includes delirium, resident discomfort, environmental over-stimulation, resident fear, depression, psychosis and loss of impulse control produced by brain damage. The treatment team must first determine whether the aggression is acute or chronic (**See Decision Tree 1 on Page 55**). For chronic aggression, staff must distinguish intermittent versus continuous (**See Decision Tree 2 on Page 56**).

Many aggressive residents respond to behavioral interventions; however, some patients fail to respond to behavioral management or the episodes of aggression are so dangerous that medications are required. Rapid sedation of the acutely aggressive, dementia resident can be achieved with IM or PO neuroleptics. Chronic aggressive behavior is sometimes improved with antipsychotic medications, especially when the symptoms result from psychotic beliefs. The resident who believes that he is being attacked, robbed, beaten, and stalked may improve with typical or atypical antipsychotic medications. The newer atypical

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antipsychotic medications have fewer side-effects but few of these medications have injectable forms. All antipsychotics may lessen these symptoms and improve behavior.

Residents with significant depression or anxiety may become aggressive as a consequence of altered mood. Antianxiety medications, e.g., Xanax, Valium, rarely improve long-term aggressive behavior and sometimes disinhibit or confuse the resident sufficiently that aggressive symptoms worsen. Many demented residents are unable to describe depressive mood and staff must assess behaviors like social withdrawal, weight loss and crying. The depressed, aggressive resident should be treated with appropriate antidepressant medication and alleviation of depressive symptoms may substantially improve anxiety.

Pharmacological management of aggressive behavior requires that staff document potential harm to the resident, other individuals, or severe disruption of the therapeutic environment. Medications are not appropriate for annoying behavior.

Episodic Hostile Behavior:

The resident with episodic, hostile behavior poses a unique challenge to the long-term care treatment staff. This individual may become physically aggressive once or twice per week without clear warning. These outbursts may become so severe as to require interventions by multiple staff and PRN medication. Some residents with intermittent aggression may not respond to behavioral interventions and these individuals may not manifest psychotic or depressive symptoms. Anticonvulsant medications may help curb this episodic, impulsive, aggressive behavior. Valproic

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acid, i.e., depakote, has been demonstrated to be effective in aggressive elders when blood levels are titrated into the therapeutic range. The standard initiation dose is 250 mg per day (e.g., 250 qhs) with gradual titration to a blood level of 60-100. Dosages can be increased by 250mg per week based on blood levels. The resident should have sustained therapeutic blood level for 2 to 6 weeks prior to determining effectiveness of the medications. Doses that produce blood levels over 100 are rarely helpful and frequently produce complications such as falls and sedation. Blood counts should be monitored for drops in platelet counts.

Carbamazepine, i.e., tegretol, can calm the impulsive demented resident but this anticonvulsant is slightly more sedating than valproic acid. Blood counts and liver function studies should be completed prior to initiation and dosages can start at 100mg at bedtime. Tegretol has a short half-life and split dosing helps sustain blood levels. Doses should be titrated in 100mg increments to a blood level between 4 and 8. Blood counts should be monitored on a regular basis to detect neutropenia. Tegretol has several significant side effects including sedation, increased falls and suppression of bone marrow. Occasional residents become hyponatremic, e.g., sodium 120-130. Tegretol may alter metabolism of other cardiovascular medications and your consulting pharmacist can advise your physician on these risks.

The anticonvulsant, gabapentine (Neurontin), is presently used for some psychiatric problems. The efficacy and long-term complication rate from usage of

this medication and several other newer anticonvulsants awaits further studies in demented residents with behavioral problems.

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Residents who respond to tegretol or valproic acid should be treated for at least 6 months. Residents who experience few side effects from these psychotropic medications should continue for an additional 6 months when the behavior is dangerous or severely disruptive. Many residents become hostile or combative as a part of delirium and these individuals should be considered for dose reduction at 6 months unless the resident has repeated bouts of delirium. Residents who have re-occurring symptoms following dose reduction should have an additional year of sustained therapy prior to repeat dose discontinuation. The rationale for continued therapy must be documented in the record for medicolegal reasons and these notes prevent problems with nursing home surveyors. Many hostile, impulsive behaviors decline as the resident's dementia progresses.

Sexual Aggression

Few dementia residents with sexually aggressive behavior are expressing erotic drives. Most aggressive touching or disrobing behavior will not result in sexual intercourse. Some demented residents will climb into bed with other residents but this does not result from sexual desires. Much "sexual" behavior is similar to activities exhibited by a 16-month old child, i.e., disrobing, touching, self-fondling. Few demented residents are capable of completing a sexual act. Sexually aggressive behavior is treatable like other forms of aggressive behavior (**See Segment on Sexual Aggression on Page 37**).

Treatment-Resistant Aggression

Aggressive residents who fail to respond to several medications should be referred to a geriatric psychiatry inpatient unit for proper evaluation and psychotropic

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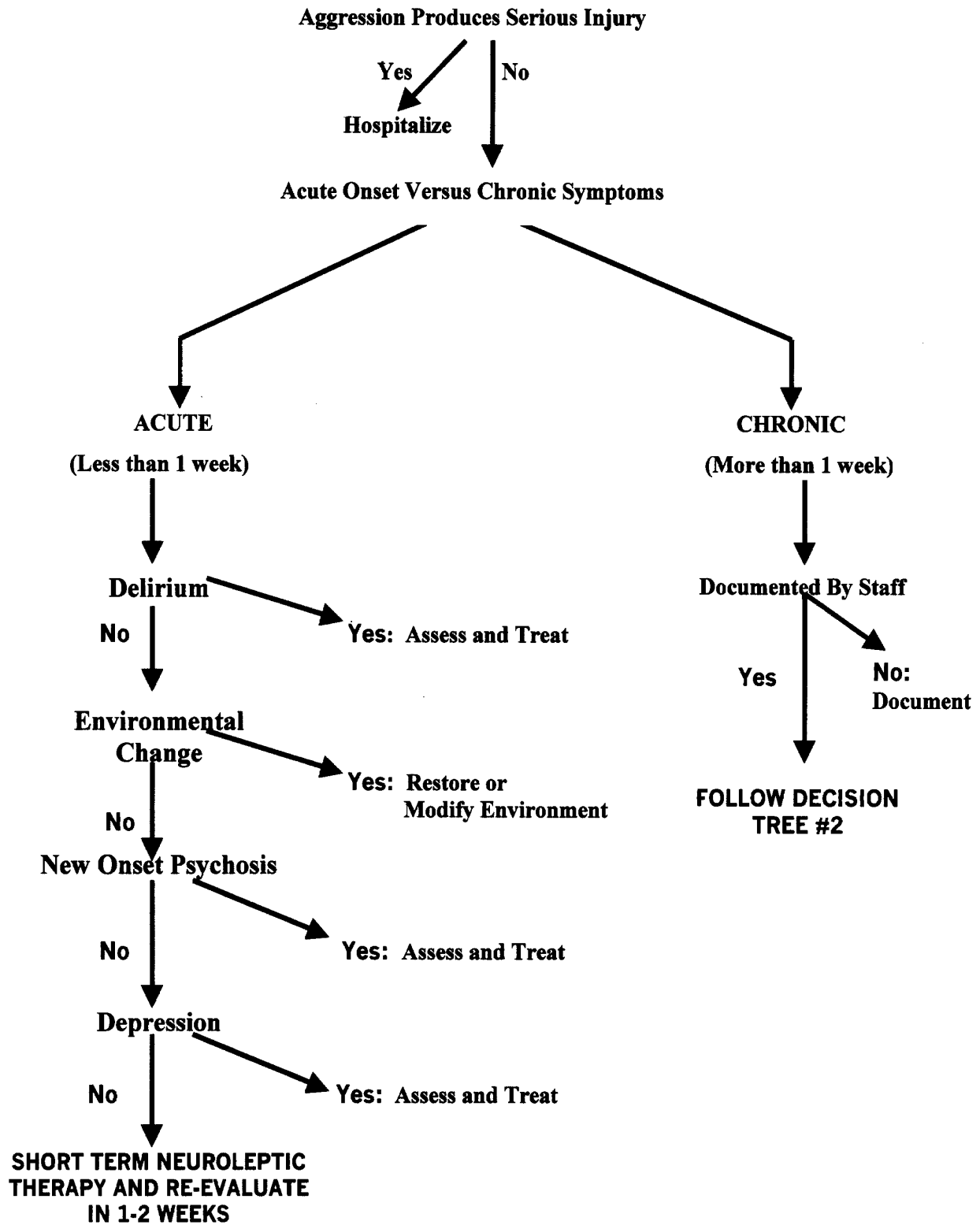
medication titration. Difficult residents who require complex psychopharmacology such as combinations of antipsychotics, mood stabilizers or use of toxic medications such as lithium, are better managed by an inpatient geriatric psychiatry unit. A typical geriatric psychiatry inpatient unit has a board certified geriatric psychiatrist as the director and geriatric mental health professionals who manage the residents. These units have specialized services with highly trained professionals who provide detailed assessments and avoid over-sedation or restraints.

A very small number of persistently aggressive residents require substantial sedation to assure individual's safety. These residents constitute a small fraction of all elderly residents with neuropsychiatric disabilities and such individuals are usually seriously, persistently mentally ill with a long history of severe aggressive behavior.

SUMMARY

Management of aggression requires a careful clinical assessment, behavioral interventions and the sequential use of psychotropic medications. Most aggressive behavior can be managed by a combination of behavioral interventions and psychopharmacology. Treatment-resistant residents should be referred to geriatric psychiatry inpatient units.

DECISION TREE 1
ASSESSMENT OF AGGRESSION



DECISION TREE 2

ASSESSMENT OF CHRONIC AGGRESSION

Intermittent Versus Continuous

Intermittent Once or Twice Per Month

Continuous Daily or Weekly

Provoked

No

Yes: Environmental Manipulation

Specific Situation or ADL Activity

No

Yes: Modify Situation or ADL Activity

Aggression Produces Threat of Harm to Self or Others

No

Monitor Status

Yes: Sequential Trial with Medications

Sequential Drug Trials

- Tegretol
- Valproic Acid
- Neuroleptic

Improved

No

Refer to Geriatric Center

Yes

Continue for 6 months

New Medication

No

Yes: Stop Medication

New Pain or Medical Problem

No

Yes: Treat Pain or Medical Problem

Environmental Change

No

Yes: Correct Environment

Psychosis

No

Yes: Treat with antipsychotics

Depression

Yes: Treat with antidepressants

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SECTION 9

ASSESSMENT AND MANAGEMENT OF SUNDOWNING BEHAVIOR

Causes of Sundowning

Sundowning refers to agitation and hyperactivity that begins in the early to mid afternoon and worsens over the course of the evening. Nocturnal agitation or sundowning is common in persons with dementia and as many as 25% of mid-stage demented patients will develop this symptom. The appropriate intervention for sundowning is: 1) assessment, 2) behavioral management, and then 3) pharmacological interventions. Sundowning can be a troublesome behavior in the nursing home and exhausting to family caregivers.

The disruption of sleep-wake cycles is common in persons with mid-stage dementia. The parts of the brain that control daily sleep-wake cycles can be damaged by all types of dementia and the body's internal clock is often reset by these brain abnormalities. Other problems can cause a patient to wander at night and become more agitated later in the day. Hunger, fear, pain, and urinary incontinence may contribute to a patient's restlessness and agitation (**See Wandering Article-Section 5**). Distress and anxiety may become worse as the resident becomes more fatigued over the course of the day. Depression can also reverse normal sleep cycles and disrupt nighttime sleep in a demented patient. Most sundowning behavior begins in mid-stage dementia and slowly worsens as cognitive function is lost. Sundowning in mild dementia or rapidly worsening symptoms suggest causes beyond dementia, e.g., delirium.

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Staff must assess for potential behavioral causes of sundowning and correct each problem with basic interventions such as hydration, snacks, etc. Most sundowning behavior begins slowly and gradually. Abrupt onset of nocturnal confusion and agitation suggests delirium. This symptom warrants the standard delirium evaluation. Residents with symptoms of depression should be treated for six weeks with adequate doses of antidepressants. Worsening of psychotic symptoms in the evening may warrant the prescription of antipsychotic medications.

Treatment of Sundowning

The pharmacological management of sundowning focuses on treating specific underlying syndromes such as psychosis, depression, etc. The use of sedatives, i.e., neuroleptics or benzodiazepines, has minimal value in attempting to reset the sleep cycle. Bedtime sedation can be achieved with low doses of a sedating medication such as deseryl, i.e., 25-50mgm hs. Antihistamines, like diphenhydramine, i.e., benadryl, do not help induce sleep, but rather these medications worsen confusion and precipitate surveyor review in nursing homes. Severe, disruptive nocturnal agitation can be treated with a sedating antipsychotic medication, such as quetiapine that is initiated in divided doses prior to the typical onset time of symptoms. For example, a patient who becomes agitated at 3pm or 4pm, should receive a small amount of a sedating antipsychotic, e.g., seroquel, 25mgm at 2pm with a second dose at 5pm and the rest of the medication at bedtime (*See A Short Practical Guide for Psychotropic Medications in Dementia Patients handbook*).

Some patients are restless and agitated throughout the night despite all efforts to improve the behaviors. These patients must have appropriate monitoring and

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behavioral management to avoid dangerous confrontations with other residents. This type of chronic behavior will often “burnout” over a 6 to 24-month period.

Some patients with sundowning will become hostile during redirection. Impulsive, aggressive behavior during the nighttime hours can be treated like any other impulsive behavior with anticonvulsants, e.g., depakote or tegretol. Although the medication will not stop the sundowning, it will curb the impulsive behavior produced by the sundowning syndrome.

SUMMARY

Sundowning is nocturnal agitation produced by brain damage that disrupts the brain’s internal clock. Sundowning behavior is managed with a careful assessment and treatment of potential causes. Hypnotic agents, i.e., sleeping medication, are rarely effective for long-term management.

SUNDOWNING FACT SHEET

1. Sundowning behavior is restlessness or agitation that may begin in the early afternoon.
2. The body's internal clock may be damaged by all types of dementia.
3. Evaluation of sundowning behavior should exclude hunger, thirst, pain, fear, and boredom.
4. Patients may become more psychotic or confused in the afternoon and evening.
5. Schedule daily activities in the morning.
6. Psychotic symptoms can be treated with sedating antipsychotics in the afternoon.
7. Schedule simple, calming activities in the afternoon.
8. Sedating hypnotics, i.e., sleeping pills rarely improve sundowning.
9. Medications will not reset a person's internal clock.
10. Some residents will improve as the dementia worsens.

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SECTION 10

ASSESSMENT AND MANAGEMENT OF URINARY OR FECAL INCONTINENCE

Proper use of the toilet requires a complex mixture of motivation, visual recognition, and motor skills. Many Alzheimer patients develop incontinence that causes institutional placement in the middle-stages of their dementia. Demented patients develop fecal incontinence later in the disease than urinary incontinence. The typical Alzheimer patient develops episodic urinary incontinence that slowly progresses over a period of years to total loss of bladder control. A similar pattern is seen with bowel control. The rapid onset of urinary or fecal incontinence suggests that a patient has developed a new behavioral or medical problem that has diminished their sphincter control. Alzheimer patients rarely use urinary or fecal incontinence to manipulate caregivers and the staff should always assume that incontinence is beyond the control of the patient.

Age-related Changes in Bladder Function:

Both males and females have specific age-related physiological changes that increase the likelihood of urinary incontinence. The prostate gland surrounds the male urethra as this tubular structure exits the bladder. Most males over the age of 65 develop benign prostatic hypertrophy, i.e., BPH that disrupts the normal flow of urine and produces the symptoms of frequency or urgency. Many women develop relaxation of pelvic musculature that allows the bladder to sag within the pelvis and diminish their sphincter control. Bowel control remains intact for most older persons.

Assessment of Incontinence:

The assessment of urinary or fecal continence begins with a careful clinical history to define the onset and features of the problem. The incontinent patient needs a

medical evaluation that includes a urinalysis and rectal examination for males to detect prostatic enlargement or infection, i.e., prostatitis. Abrupt onset incontinence frequently results from urinary tract infections, rectal impaction, prostatic infection, i.e., prostatitis, or new medications that either disrupt bladder function or cause confusion. Patients may become acutely incontinent as a result of delirium, e.g., during hospitalization and these patients can be retrained to resume continence. Incontinence produced by progressive brain damage is not retrainable and staff must adapt patient management strategies to accommodate this disability.

Dementia produces incontinence through several mechanisms. Frontal lobe damage can make a patient indifferent to the need for continence. Parietal and occipital lobe damage will diminish the person's capacity to recognize bathroom features, e.g., the shape of the toilet or sink, and frontal/parietal damage will reduce the patient's ability to manage the mechanics of disrobing, sitting, and using the toilet. Damage to deep cortical structures, i.e., the insula cortex may diminish the patient's ability to interpret internal sensations of bladder distention, i.e., the sense of a full bladder.

Behavioral Management of Urinary Incontinence:

A toileting schedule should include: 1) leading the patient to the bathroom, 2) assisting with the disrobing, 3) encouraging the patients to sit, and 4) monitoring to assure that the patient does not prematurely stand and leave the toilet. Toileting should be done with respect for the resident's privacy and dignity. Following the completion of toileting, staff should note whether the patient has had a bowel movement or emptied their bladder and then assure that post-toileting hygiene is

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completed. Patients should be assisted with hand washing. Toileting should be repeated every two hours while the patient is awake.

Ambulatory patients who are managed with continence products, i.e., adult diapers, should continue to be toileted until such efforts are counter-productive, e.g., patient fights during attempts to place the patient on the commode. Staff should maximize natural toileting since the use of diapers could increase the likelihood of skin damage. Most end-stage dementia patients are usually incontinent and staff must maintain hygiene and skin care.

Fecal Incontinence:

Fecal incontinence occurs late in Alzheimer's disease. Loss of bowel control in early stages of dementia suggests some physical problem, e.g., damage to nerves that control rectal sphincter, severe disabling hemorrhoids, rectal tumors, etc. Fecal smearing, e.g., walls or furniture, is a troublesome behavior that occurs in a small number of demented patients; however, fecal smearing is more common in persons with mental retardation. The onset of fecal smearing suggests a physical, psychiatric, or neurological disorder rather than an expected consequence of dementia. Problems such as delirium, psychosis, rectal impaction, thrombosed hemorrhoids, or other physical problems, should be excluded. Obstipation or impaction are common causes of smearing. Psychotropic medications are not effective for fecal smearing, and staff must monitor the patient carefully to assure toileting and bowel function.

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Fecal Obstipation:

Fecal obstipation is the massive accumulation of feces within the colon that occurs with dehydration, low fiber diet, use of anticholinergic medications, as well as recurrent rectal impaction. Patients who receive long-term antipsychotics, e.g., chronic schizophrenics, are at higher risks for developing fecal obstipation. Fecal obstipation can be assessed with a rectal examination and physical assessment to palpate the colon as well as a flat plate of the abdomen to demonstrate copious amounts of hardened feces within the colon. These patients require dietary monitoring, good hydration, and consistent bowel cleansing to correct the bowel dysfunction. Staff must assure that aggressive bowel cleansing does not produce diarrhea, dehydration, or electrolyte abnormalities.

“Digging” at the rectum occurs in some demented patients and may result from hemorrhoids, impaction, or skin problems in the perineal area. Females may dig at the rectal region because they have vaginal infections, e.g., candida, following antibiotic therapy or thinning of the skin of the vulva due to estrogen deficiency. Males may dig at the rectal area because of hemorrhoids or impaction. Any patient who is “digging” at their rectal region should have careful perineal examination and women should have a vaginal examination to exclude other causes of perineal discomfort. Hemorrhoids are treated with topical rectal medication. Vaginitis is treated with antimicrobials, and atrophic skin changes are treated with topical estrogen cream.

Several medications for urinary incontinence are available; however, these drugs may produce confusion in Alzheimer patients. Drugs like Tofranil and Ditropan can be prescribed for Alzheimer patients; however, the cognitive and psychiatric status of the medication recipient should be monitored during the prescription.

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SUMMARY

Urinary incontinence occurs in many mid or late-stage demented patients. Loss of bowel or bladder control is a major clinical problem for demented residents. Urinary incontinence requires a careful clinical assessment followed by a structured toileting schedule. Fecal incontinence generally occurs in the latter stages of dementia and responds best to a toileting schedule following proper evaluation. Adult continence products, i.e., diapers, should be combined with toileting schedules to assure that residents have minimal opportunities to soil themselves.

SECTION 10

FACT SHEET ON URINARY AND FECAL INCONTINENCE IN DEMENTIA

1. Urinary incontinence is common in the mid to late-stages of dementia.
2. Urinary incontinence rarely begins abruptly.
3. Most early stage dementia patients can control bowel and bladder function.
4. Urinary or fecal incontinence requires a medical evaluation to exclude physical causes.
5. Demented patients forget where the toilet is, what the toilet is, and how to use the toilet.
6. Bladder infections are common in older women.
7. Enlarged prostate glands are common in older men.
8. Medications that improve urinary continence may confuse patients.
9. Fecal smearing is usually a manifestation of neurological, psychiatric, or medical problems.
10. Good hydration, attention to diet, and good toileting schedules, diminishes the likelihood of problems with bowel control.

SECTION 11

Comprehensive Multidisciplinary Assessment of the Demented Nursing Home Resident with Weight Loss

Nursing home regulations have specific guidelines to define weight loss in the nursing home resident. A weight change is considered severe in the following conditions: loss of five pounds in one month, loss of 7.5% of body weight or greater in three months, loss of ten percent of body weight or greater in six months. Although dementia residents lose weight over time, this “normal” decline does not exceed the OBRA guidelines, e.g., 1-2 pounds per year. Significant reductions in body mass must be explained in the medical record. Some weight loss does not require investigation, e.g., residents on weight reduction programs who are obese. Other residents may sustain a certain weight but actually lose body mass, e.g., residents who lose lean body mass but gain fluid weight due to fluid retention. Those individuals with documented weight loss that meet or exceed nursing home guidelines require a careful multidisciplinary evaluation that is clearly documented in the medical record.

Weight loss in the neuropsychiatric resident can be produced by a variety of psychiatric, medical, behavioral, environmental, or dietary issues. Weight loss requires a comprehensive assessment because of the serious consequences of diminished body mass. The medical doctor, nurse practitioner, psychiatrist, dietician, nursing staff, and dentist may play a role in assessment or management of weight loss.

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The standard weight loss assessment begins with the dietician who reviews the resident diet, calorie intake, eating behavior during meals, and confirms that accurate weights were obtained. The dietician must determine whether the appropriate type of diet is provided with appropriate frequency of snacking, supplementation, and dining hall support. The dietician should observe the resident on a minimum of two separate occasions over at least a 15-minute period during the feeding process. The dietician must determine the quality and character of eating dysfunction, e.g., does the resident eat every meal or just some meals, does the resident begin and then terminate, does the resident eat for several days and then no oral intake?

The medical doctor or nurse practitioner should document a physical examination on the resident who loses weight. The examination should include appropriate oral and neck examination to exclude oropharyngeal disease. The examination should include the abdomen to exclude tenderness or fecal obstipation and a rectal examination to exclude impaction. A flat plate X-ray of the abdomen to assess colonic distension and physical examination may assess fecal obstipation. The physician should assess for other associated medical causes of diminished oral intake, e.g., GERD, ulcers, diverticulitis, chronic pain, or congestive heart failure. The physician may order laboratory tests as indicated e.g., albumin, pre-albumin, and exclude metabolic causes for diminished appetite.

The physicians or practitioners should examine the resident to exclude depression, delirium, and psychosis that will diminish the resident's appetite or impair their ability to chew/swallow. The physician should assess the stage of dementia to

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determine whether the person is sufficiently demented that they are now developing chewing/swallowing apraxia. The physician or practitioner should review medications and extra-pyramidal symptoms to determine whether the resident suffers from dysarthria, psychotropic medication induced dysphasia or esophageal dysmotility. The treating physician must exclude diminished appetite from prescription of psychotropic medications e.g., stimulants, anti-depressants, antipsychotics. The physician should assess whether new medications were added that may alter metabolism of existing psychotropic medications, e.g., alteration of P450 system. Levels can be obtained when appropriate. A neurology or psychiatry consultation may be helpful for complex neuropsychiatric cases.

The nursing staff should review the procedure for feeding the resident and the staff who are assigned to assist with feeding. Nursing staff should determine whether one-to-one attention is required during meals and the level of skill for the staff who are performing the one-to-one. Nursing staff should also assess the frequency and effectiveness of snacking and hydration procedure. Dehydrated patients will often stop eating. The nursing staff should assess the resident's environment to determine whether a new environmental stressor was introduced e.g., new roommate, chaos on the inpatient unit, loss of an experienced caregiver, etc.

The treatment team should identify as many possible causes of weight loss and staff should attempt to correct these problems through behavioral, nursing or environmental manipulation. Medications can be prescribed to enhance appetite;

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however, literature indicates that the success of these drugs, e.g., Megace, Marinol, are limited in neuropsychiatric residents. Certain appetite stimulants, e.g., periactin, are not helpful in demented residents.

Many advanced stage Alzheimer resident begin to loose weight when these individuals manifest swallowing/chewing dyspraxia or apraxia. Predictors of swallowing apraxia include advanced dementia, expressive aphasia, and frequent bouts of choking or aspiration pneumonia. The literature on the value of PEG tubes indicates that this intervention is not helpful for most end-stage dementia residents. A first step in defining the role of a PEG tube is to identify a surrogate decision-maker or commence the process of appointing a surrogate decision-maker. The treatment team should provide the family with a careful explanation of the value and limitation of PEG tubes and these decision-makers should be afforded the opportunity to choose hospice care for appropriate residents. Nasogastric feeding has limited value with high risk for aspiration, and the need for restraints to prevent tube extraction. Nasogastric tubes are only meant as a short term, i.e., less than one to two weeks option for residents with correctable or resolvable problems. Long term nutritional support can be achieved via PEG tubes for patients with mild or moderate dementia. Multiple clinical studies conclude that PEG tubes fail to improve quality of life and nutrition for patients with advanced disease. Consensus expert opinion discourages the insertion of PEG tubes in terminal dementia patients. End-stage residents are better managed with hospice care. Families must be apprised of the risk to benefit ratio for PEG tubes and the likelihood of recurrent aspiration from swallowing apraxia. Ultimately, the treatment team should follow the advanced directive of the resident or the direction of the surrogate caregiver.

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SECTION 12

ASSESSMENT AND MANAGEMENT OF RESIDENTS WHO FALL

Falls are common in the elderly and older persons are prone to injury from such accidents. Falls occur in 30-40% of community-dwellings elders and up to 60% of elders in long term care facilities. How do you define too many falls? The treatment team must carefully assess residents with numerous falls to determine the cause and prevent further injury. Fractures occur in 5% of all elders who fall and other injuries occur in an additional 5% of this group. Hip fractures occur in 1-2% of elders who fall. Most gait abnormalities in older patients result from multiple medical and neurological problems. Fractures occur in 3-7% of demented elders per year. And about 11% of demented patients become non-ambulatory per year. A small number of demented patients, about 0.8% per year, will fracture with minimal or no trauma e.g., standing up. Significant numbers of injuries, i.e., up to 35% occur in non-ambulatory dementia patients during transfer or positioning. Regardless of which statistic is used, elderly patients with dementia are at serious risk for falls and injury. A falls assessment involves a complete evaluation (**See Table 1 on Page 75**).

The definition of falls can be complex. Some patients fall and clearly report the event. Demented patients may be found on the floor without explanation. Mentally ill or mentally retarded residents may simply lie on the floor. The nursing home surveyors consider any event where a patient is found on the floor without explanation to be a fall. A careful evaluation by the physicians, nurses, and physical therapist is required for any patient with repeated falls or any resident injury that results from a fall.

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The nursing service should provide the clinical assessment team all available information about the circumstances of the event. The clinician needs to know whether the patient was pushed or fell and the circumstances surrounding the incident e.g., was the patient standing from the sitting position. Nursing home environmental risk factors should be surveyed including clutter, congestion, or the proximity of aggressive patients who are poorly supervised. Clothing and footwear should be reviewed as a cause of instability. Staff should determine whether the patient was properly using devices e.g., canes, and walkers.

The treating physician should perform a basic neurological examination to exclude new-onset hemiparesis as well as an assessment of the gait that includes standing and turning. Peripheral neuropathy produced by diabetes, vascular disease, or chronic alcohol abuse can reduce sensory function, e.g., positional sense as well as motor strength. The neurological examination and gait assessment should be included in the medical record. Orthostatic blood pressures should be obtained on several occasions. The treatment team can then decide what additional medical intervention, e.g., EKG to rule out arrhythmia Halter monitor, CT examination, etc. are appropriate for the assessment of the patient. Clinicians should treat correctable problems, e.g., dehydration, orthostatic hypotension, cardiac dysrhythmias, etc.

Table 1

<u>CAUSES OF FALLS</u>
• Neurological
• Behavioral
• Pharmacological
• Medical

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The physician should review psychotropic medications to assure that the patient is not excessively sedated or ataxic as a result of medications. Old antipsychotics and benzodiazepines have higher risk for gait problems. The treatment team must also determine whether behavioral problems are an antecedent to the patient's injury, e.g., excessive wandering, fighting, etc. The physician should assess whether the patient is developing a gait apraxia as a result of dementia. The psychiatrist must exclude delirium as a potential etiology for unsteadiness. The physical therapist should assess the patient to determine stability of gait and appropriateness of gait training. Moderate to severely demented residents cannot learn new skills to prevent falls. The management of falls depends on the circumstances and causes of these injuries.

The management of an unsteady patient begins with a complete assessment of causes and treatment of specific underlying diseases that produce instability or environmental circumstances that cause falls. The physical therapist should construct the necessary strengthening or rehabilitative program to maximize patient function. Medications that produce sedation or orthostasis can be altered to reduce risk for falls (**See Table 2 on Page 77**).

Restraints are not a management strategy for a patient with falls. Merry walkers, assistive devices, low beds, beanbags, and other interventions should be considered for utilization in patients with uncorrectable weakness or instability. Hip pads, i.e., hipsters, and gait belts may be effective in some patients. The treatment team should address behavioral or psychiatric symptoms that promote instability or falls.

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Patients who continue to fall despite maximum medical, psychiatric, and rehabilitative interventions should receive close monitoring to avoid or reduce risk for injury. Intermittent or one-to-one observation can be use in selected specific cases that warrant this allocation of resources and restriction of patient rights.

Some patients continue to fall despite maximum medical, psychiatric, nursing, and environmental manipulations. The families should be informed of all interventions employed by treatment teams to reassure caregivers that appropriate protections are employed. All aspects of assessment, intervention, and communications should be recorded in the medical record. A second opinion can be obtained from a designated specialist such as a neurologist or geriatrician when clinically indicated.

Table 2

MEDICATIONS WITH POTENTIAL RISK FOR FALLS	
DRUG CLASS	TOXICITY
ANTIPSYCHOTIC MEDICATIONS	
<ul style="list-style-type: none"> • Old high potency medications, e.g., haldol, prolixin • Old low potency medications, e.g., Mellaril 	<p>Sedation, Parkinsons</p> <p>Orthostasis, sedation</p>
BENZODIAZEPINES	
<ul style="list-style-type: none"> • Ativan, Valium 	Sedation, confusion, ataxia
ANTIHYPERTENSIVES	Orthostatic HBP
ANTIDEPRESSANTS (TCA), e.g., Elavil, Imipramin	Orthostasis

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Falls are not always evidence of poor care. Falls can be an unavoidable consequence of dementia when the treatment team: (1) conducts a complete, thorough resident evaluation, (2) implements all reasonable measures, (3) seeks appropriate consultation, (4) documents intervention and implementations, (5) continues to adjust management strategy, and (6) communicates with family. Adequate documentation assures staff and family that appropriate care was provided as well as protects the facility against future litigation.

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SECTION 13

RESISTENCE DURING ACTIVITIES OF DAILY LIVING: BATHING THE DEMENTIA RESIDENT

Some demented patients may resist during ADL function. Bathing can be dangerous for both resident and staff. Bathing is not a natural human activity but is set by social and cultural norms. It is not a natural human instinct to bathe every day. In some cultures, individuals bathe once a week or once a month. The bathing pattern of a dementia resident should resemble the resident's pattern prior to onset of the disease unless the resident has specific hygiene needs. An old farmer with dementia who bathed once per week will expect to bathe at this frequency. Likewise, the time of bathing should be determined based on resident's cognitive function and past cultural experience. Residents who bathed in the evening should bathe in the evening. All attempts should be made to maintain normalcy with the resident. Some residents who "sundown" must be bathed in the morning. Incontinent residents who awake soiled in the morning must be bathed and changed. Psychotic residents may be convinced that family or staff will harm them when they disrobe or enter the bathing area. The rationale for a specific bathing pattern should be recorded in the resident's record.

Bathing is a complex behavioral program that frequently includes bathing, dressing and toileting. Bathing can be broken into four phases: (1) undressing, (2) introduction into the shower stall or tub, (3) washing, and (4) drying and re-dressing. Residents may struggle during any stage for a variety of reasons. Some residents become temporarily confused with the introduction of new medications or as a result of a new medical illness (i.e., delirium).

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Staff should organize themselves prior to the bathing activity by gathering necessary toileting items and clothing. Bathing should be accomplished with sufficient personnel to protect staff and patients. Staff should never leave a confused patient unattended during bathing because falls commonly occur in the bathroom.

UNDRESSING

Most older residents retain a normal sense of modesty and resist undressing. Patients should never be undressed in public places. Frightened, disoriented residents may forget the face of caregiver or their nursing staff. Middle stage Alzheimer residents frequently struggle during bathing because they forget how to undress and cannot communicate with staff. Staff must communicate through both verbal and non-verbal channels to assure that the resident receives their message. Always approach the resident from the front when possible. Make sure room temperature is appropriate for disrobing. Always smile and speak calmly. Never demonstrate frustration to the resident. Keep the patient covered whenever possible, e.g., leave a robe on their shoulders until they are in the water.

INTRODUCTION INTO THE BATH

Showers and bathtubs are dangerous for both resident and staff or caregiver. Bathtubs and shower should be fitted with no-skid surfaces and grab bars to minimize risks for falls and fractured hips. Residents should remain in bathrobes until physically placed in the bathing area. Residents should be toileted immediately prior to bathing to prevent defecation during or after the bathing process. Mid and late stage residents are particularly at risk for falls during introduction into the bathing area. Residents forget how to pick up legs, sit in

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bathtubs, and stabilize themselves during the transfer. Beware of asking residents to step on cold, hot or slippery surfaces. Startled residents become alarmed and attempt to flee or strikeout.

WASHING

Staff must secure all materials for the bath including soap, towels, etc., prior to introducing the resident into the bathing area. Do not leave the resident unattended in the bath area to retrieve bathing items. Elderly residents are usually quite modest and do not want other people watching them. Mid-stage demented residents frequently forget how to wash themselves. More complex washing action, such as shampooing of hair, may cause problems for residents. For example, residents may not understand to close their eyes to prevent burning. Staff or family must properly wash all skin folds and creases. The washing of genitals must be conducted with great delicacy and privacy. Residents being bathed or showered must have appropriate temperature for the water. Residents who self-bathe must have the household hot water temperature lowered to 120° to prevent scalding by adjusting the hot water heater. Shower-heads should not direct water into the resident's face. Long-term care staff should gather as much information about past bathing habits and techniques as possible. Visual and hearing impaired residents may be at greater risks for falls during the bathing process. Residents with past history of falls, those receiving psychotropic medications, and residents recovering from recent medical problems are also at greater risks for falls. Frail elders are more prone to skin tears following a bath while their loose skin is

saturated with water. Staff must maintain control of the patient to avoid grabbing injuries, e.g., tearing skin on the backs of hands or arms.

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DRYING AND RE-DRESSING

Dementia residents may not remember how to dry themselves, brush hair, use a hair dryer, etc. Residents may become distressed when asked to perform these activities. Keep the resident in a warm room until they are completely dry and clothed. Clothing should be laid out in advance to assure a rapid sequence from drying to dressing. Residents with dressing apraxia will not remember how to clothe themselves. Staff must determine level of ability and allow residents to dress themselves as much as possible.

CONCLUSION

Major difficulties with bathing usually result from multiple resident disabilities. Training, organization, and adequate manpower are key elements. Some hostile residents will need to be bathed less frequently to avoid physical confrontation. These decisions must be made on a case-by-case and day-by-day basis.