

# Where is she going?

By Amie Martin , OTR/L

There is probably a resident in your facility that comes to mind when “wandering” is mentioned. Wandering & pacing behaviors can be problematic if the resident is burning too many calories, is excessively agitated, proceeds into areas that are off limits, or is at risk for becoming lost. As fatigue sets in, the patient may also be at greater risk of falling. Caregivers should realize that the patient does have a reason for this behavior, although the reason may not always be easily determined.

Factors that may contribute to wandering behavior include confusion, pain, loneliness, and loss of spatial orientation. There is a “strong need to maintain contact with a familiar environment” per researchers at the Colorado foundation for Medical Care, and patient’s wandering may be their means of trying to find home. According to HealingWell.com, dementia patients may suffer from an affective response to the perception of loss. HUH??? “This means that (they) still have memories and perceptions of activities that they use to enjoy. They miss being able to drive a car, cook, or care for children.” “Behaviors” and agitation may be the only means to express what they are feeling, when other means of communication are impaired.. Another theory is that residents with cognitive deficits that lack the ability to carry on a social conversation, follow a television program, or enjoy a book may seek sensory stimulation through pacing & wandering. Decreased hearing and vision, in addition to cognitive impairments, may exacerbate the sensory deficit. The wandering behavior may be worse at night, when resident’s may feel less safe and try to stay awake to feel more secure. It is estimated that 1 in 10 SNF residents may have wandering behavior.

Treatment should generally focus on relieving agitation and modifying the environment for safety. Here are some general tips to consider when addressing wandering/pacing behavior with your patients and to include in your staff education or functional maintenance programs:

1. Create a safe environment for wandering, including locking areas that are off limits and preventing access to unsafe substances. Use a wander guard system. Use night lights. Place a dark mat in front of doors or areas that are off limits (they may perceptually see this as a hole in the floor and not try to step near it.) Use stop signs or disguise doorways & exits ([Alzheimers Proofing Your Home](#) by Mark Warner is a great resource, and there are many catalog sites on the internet for ordering door disguises and other helpful tools.)
2. Offer alternative reciprocal motor activity to replace pacing, if the resident is unsafe.



Rocking chairs and reciprocal exercisers (i.e. restorators) are sometimes good alternatives.

3. Keep purses, umbrellas and coats (or other items that the patient associates with leaving) out of sight.
4. Remind staff to guard their personal conversations. Change of shift times can be difficult. If staff are discussing what they are making for dinner or plans to pick up children from school, the confused resident may become agitated and eager to leave to take care of their responsibilities at “home.”
5. If lost, search in the direction of the wanderer’s dominant hand, as they tend to travel in their dominant direction. If they have a tendency to elope, have a written plan to follow before a situation arises where they become lost. Dress them in brightly colored or distinctive clothing. Consider purchasing a gadget that beeps when the searcher claps or whistles. Look within 100 feet of the road first, as they tend to start on roads and remain close by.
6. If calorie loss is a problem, provide finger foods to eat on the go and evaluate for an individualized feeding program or restorative dining. Cloth tool belts for men and large pocket aprons for women are good on-the-go snack carriers.
7. Assess and treat pain (non-verbal pain indicators screen) and depression (GDS-Geriatric Depression Screen). If the resident is spending significant amounts of time on their feet, intervene for painful joints.
8. Provide vision and hearing screens to ascertain sensory deficits. Make sure hearing aids and glasses are used if needed.
9. Provide appropriate daytime activities for each resident’s established cognitive level based on your ACLS and other cognitive assessments. Write an activities FMP with specific suggestions for enjoyable diversional pursuits to incorporate into stationary times and promote rest.
10. Provide a fall risk analysis and fall risk reduction program.
11. Assess sleep patterns and fatigue levels. They may benefit from a FMP with a rest/wake schedule including naps 2x/day in an easy chair or atop the bed covers. Another strategy is to ask every staff member to sit with a wandering resident 2 mins each day. This can add up to many rests throughout the day, incorporates time for social interaction (even if its non-verbal) and also is a good time to offer a snack and hydration.
12. Limit caffeine.
13. Provide plenty of daytime sunlight.
14. Provide a calm, structured environment.
15. Give reassurance that they are safe. Provide loving touch, if the patient approves.

Do you have other tips and suggestions that have worked with a patient with “difficult behaviors” at your facility? Please email your experiences and success stories to me at [amartin@hts1.com](mailto:amartin@hts1.com) to be shared with other therapists.

Find more helpful information on this and other dementia care topics at [www.helpguide.org](http://www.helpguide.org) , [www.alz.org](http://www.alz.org) , [www.alzbrain.org](http://www.alzbrain.org)