

# Restraint Reduction

- Assessment and Alternatives Help Guide
- Evaluation Trees
- Assessment Log/  
Intervention Care Plan

Funding for this Skilled Nursing Facility Health Care Quality Improvement Project was provided by the Health Care Financing Administration, Contract #500-96-P611. These materials were prepared and assembled by the **Colorado Foundation for Medical Care** in collaboration with the **Colorado Department of Public Health and Environment, Health Facilities Division**, May 1998. The contents presented do not necessarily reflect HCFA policy.

# ASSESSMENT and ALTERNATIVES HELP GUIDE

## Table of Contents

	Page
<b>BASIC ASSESSMENT</b>	5
<b>ASSESSMENT TOOLS</b>	7
<b>FALLS</b>	14
<b>BEHAVIOR PROBLEMS</b>	36
<b>WANDERING</b>	55
<b>MEDICAL NECESSITY</b>	61

# ***ACKNOWLEDGMENTS***

*“One person can make a difference, and every person should try.”*  
John F. Kennedy

The Help Guide was prepared by the Colorado Foundation for Medical Care with funds provided by the Health Care Financing Administration contract # 500-96-P611 and in collaboration with organizations and individuals from throughout the state.

## **Partnership Members**

Alzheimer's Association  
Colorado Association of Homes and Services for the Aging  
Colorado Department of Health Care Policy and Financing  
Colorado Department of Public Health and Environment  
Colorado Foundation for Medical Care  
Colorado Health Care Association  
Department of Preventative Medicine and Biometrics - UCHSC  
Family Representation  
Health Care Financing Administration  
Long Term Care Staff  
Colorado Medical Directors' Association  
Nursing Home Administration  
Office of the State Attorney General  
Office of the State Ombudsman

*Appreciation is expressed to the Colorado Health Care Association for permission to include excerpts from Freeing A Half-Million People: Increasing Resident Independence Through Restraint Reduction, prepared by Diane Carter, RN, MSN for the Colorado Health Care Association, 1991.*

*Special thanks to Diane Carter, RN, MSN, Susan Smith, RN, BSN C-GNP and Karyn P. Prochoda, MD for their contributions to the development of this Help Guide along with the Assessment Log and Evaluation Trees.*

For information regarding the Help Guide, please call:

**Colorado Foundation for Medical Care**

Communications Department  
303-695-3300, Ext. 3332

This poem was found among the possessions of an elderly lady who died in the geriatric ward of a hospital. No information is available concerning her -- who she was or when she died.

## See Me

What do you see, nurses, what do you see?  
Are you thinking, when you look at me --  
A crabby old woman, not very wise,  
Uncertain of habit, with far-away eyes,  
Who dribbles her food and makes no reply,  
When you say in a loud voice -- "I do wish you'd try."

Who seems not to notice the things that you do,  
And forever is losing a stocking or shoe,  
Who unresisting or not, lets you do as you will,  
With bathing and feeding, the long day to fill.

Is that what you're thinking, is that what you see?  
Then open your eyes, nurse, you're looking at ME...  
I'll tell you who I am, as I sit here so still;  
As I rise at your bidding, as I eat at your will.

I'm a small child of ten with a father and mother,  
Brothers and sisters, who love one another,  
A young girl of sixteen with wings on her feet.  
Dreaming that soon now a lover she'll meet;  
A bride soon at twenty -- my heart gives a leap,  
Remembering the vows that I promised to keep;  
At twenty-five now I have young of my own,  
Who need me to build a secure, happy home;  
A woman of thirty, my young now grow fast,  
Bound to each other with ties that should last;  
At forty, my young sons have grown and are gone,  
But my man's beside me to see I don't mourn;  
At fifty once more babies play 'round my knee,  
Again we know children, my loved one and me.

Dark days are upon me, my husband is dead,  
I look at the future, I shudder with dread,  
For my young are all rearing young of their own,  
And I think of the years and the love that I've known;  
I'm an old woman now and nature is cruel --  
'Tis her jest to make old age look like a fool.

The body is crumbled, grace and vigor depart,  
There is now a stone where one I had a heart,  
But inside this old carcass a young girl still dwells,  
And now and again my battered heart swells.

I remember the joys, I remember the pain,  
And I'm loving and living life over again,  
I think of the years, all too few -- gone too fast,  
And accept the stark fact that nothing can last --  
So I open your eyes, nurses, open and see,  
Not a crabby old woman, look closer, nurses -- see ME!

## Basic Assessment Tool

When a patient is not feeling well or is "just not right", it is important to do a basic assessment of his or her current status. Some of the signs that indicate that something is wrong include:

The patient is:

- more confused than usual
- not eating
- incontinent
- experiencing increased swelling

This is the first diagnostic step. It is followed by basic data gathering and physical exam.

The most common acute geriatric problems:

1. UTI (urinary tract infection)
2. impaction/obstruction
3. pneumonia
4. medications
5. confusion

These acute problems are superimposed on chronic disease. Example: patient is coughing more and has existing diagnosis of COPD (chronic obstructive pulmonary disease) and CHF (congestive heart failure). What is going on and how do you figure it out?

Gather history - most important. Diagnosis frequently made on history alone, with physical exam only confirming.

**Pain** - how long, where, nature of pain (constant, intermittent, sharp, burning, aching, heavy, stabbing, boring, cramping), does pain radiate?

Examples:      burning epigastric pain - ulcer vs. gastritis  
                    burning back pain may indicate muscular/neuro pain  
                    burning abdominal - UTI (Urinary Tract Infection)  
                    heavy sternal pain - MI (Myocardial Infarction)  
                    sharp, abdominal pain - stones  
                    aching joint - arthritis

Pain is frequently denied in this population - "Grin and bear it" ethic

Decreased expectation for relief of pain

Inability to communicate, or stoicism

What makes pain better or worse, i.e.: food, rest, cold, heat, exercise.

Is there nausea? urinary burning? retention? vomiting? urinary frequency (most geriatric patients are asymptomatic)? last bowel movement - nature of bowel movement (hard, soft, tarry, brown)?

Is patient coughing more than usual, does he have chest pain - nature of pain? rib fracture vs. wall pain vs. cardiac vs. pneumonia. Are symptoms new or increased from baseline?

Be very specific but try not to guide patient.

Has patient been taking meds? sleeping? eating? Is patient sad/depressed looking? Ask him directly - Are you sad, how long?

**Chest** - nature of pain, difficulty breathing, SOB, pain radiating to arms, neck or face.

**Check Meds** - Digitalis, Theophylline, Dilantin <sup>TM</sup>, Tegretol <sup>TM</sup>, psychotropics require levels. When was last level and was it noted by physician as being acceptable? Not all meds need to be in therapeutic levels. Illness can alter normal levels. Anti-convulsants, even at therapeutic levels, can cause dizziness and sedation.

If patient unable to give history, must rely on PE. Remember baseline.

**Survey Patient** - do they look acutely ill, dehydrated, in pain?

**VS** - body temperature is least reliable measure of geriatric illness - Respiration, Heart Rate, BP better - geriatric patients frequently don't run fevers.

**Heent** - check ears, throat, palpate sinus - does patient have teeth, dentures - what condition?

**Lungs** - decreased breath sounds? Are lung sounds even, any rales? Check progress notes for baseline.

**Heart** - fast, slow, regular, irregular, is there edema? Is BP increased over baseline?

**Abdomen** - Bowel Sounds - listen for 2 minutes before deciding there are no bowel sounds. Is patient tender to palpation? Where? Is abdomen soft, hard, distended?

**Extremities** - swollen, red, painful? Has Range of Motion changed from baseline?

**Mental Status** - is it different from baseline?

**Labs** - Evaluate medication. Synthroid <sup>TM</sup>, digoxin <sup>TM</sup>, dilantin <sup>TM</sup>, Tegretol <sup>TM</sup>, psychotropics require laboratory monitoring. Again check baseline.

UA very important.

SMA6 - elevated BUN and Creatinine may indicate renal failure or simple dehydration

Check baseline levels

May need chest x-ray

CBC

Abdominal X-ray - 3 way, KUB

# Assessment Log/ Intervention Care Plan

**Document: Initial Assessment/Each Event/Actions & Results**

		Resident:	ID #:	Room #:
		Intervention		Assessment of Intervention
		What did staff do? How does this improve resident function? Permits resident access to his/her own body? Least restrictive and highest level of functioning?		How did intervention work? If not, why? If yes, why?
<b>Event #</b> ①	<b>When</b> (Date/Time) 1-27-97 1:00 AM.	Bed changed to lowest position. Changed to half siderails. Bed wheels locked. Put non-skid adhesive strips on floor, head, + foot boards to improve grip. Added night light + put call bell within reach. Checked need to void q 2 <sup>o</sup>		1-28-97 7:30 AM. Resident states "I can stand up easier" + "Easier to get to bathroom. Bell stable when locked. Resident states "can reach bell-will call." Toileted q 2 <sup>o</sup> at night.
<b>What/Where</b>	What behavior/event was observed? Where did it occur? (Be specific) Resident found on floor beside bed in his room.	Review & Comment by Charge Nurse/Restraint Committee: OK. Good followup. J Smith RN 1/29/97		1-29-97 8 AM No further falls.
<b>Who/Why</b>	Who else was present? What was happening? What may have caused or triggered behavior? No one else present. Attempting to get to bathroom. "Feet slipped + bed slid away." Bed in highest position. Rails full + up. Poor vision, did not call for help	Initials <i>SN</i>		

## INSTRUCTIONS FOR USE - ASSESSMENT LOG/INTERVENTION CARE PLAN

See other side for detailed instructions

### WHEN DO I USE THIS FORM?

- for every event for each resident
- for injury and non-injury events
- for every event until least restrictive device, allowing highest level of functioning is obtained

**REMEMBER:** An intervention is anything you do that helps!

- Maintain a separate log for each patient
- Keep information specific and brief
- Look for patterns around time, place, furniture other residents, staff or medication administration
- Try alternatives → document outcomes/results

### VERY IMPORTANT to ASK YOURSELF THE FOLLOWING KEY QUESTIONS:

- IS THIS LEAST RESTRICTIVE? If yes: ☺
- DOES THIS PERMIT RESIDENT ACCESS TO OWN BODY? If yes: ☺
- DOES THIS ACHIEVE HIGHEST LEVEL OF FUNCTIONING? If yes: ☺

### WHICH RESIDENTS NEED THIS FORM?

- anyone currently using a device
- anyone being considered for a device
- anyone who has had an incident or event such as fall, wandered, behavior problem
- Record all facility attempts to reduce restrictiveness of device, why it is least restrictive, and resident outcome
- Document briefly all monitoring, changes, and reactions to changes

Form will service as documentation of restraint RAP ⇔ Note location of RAP Summary ⇔ attach to chart as Restraint Care Plan.

Use as Interdisciplinary Team approach. Talk with families to better understand resident's needs.

Copy as necessary for supervisory review and Restraint Committee.

Colorado Foundation for Medical Care

Funding provided by

HCFA Contract #500-96-P611

**Event #:** Indicate number. Keep numbers consecutive so events are easy to track.

**When:** Indicate date and time. Be specific. Use AM and PM indicators. Indicate if during shift change.

**Example:** 7/4/97, 3:00 p.m., during evening shift change.

**What/Where:** Describe what happened to/with resident. Be specific as to where it occurred.

**Example:** Fell while leaving bathroom, at doorway. Resident found on floor, no injury or cuts. Able to walk.

**Who/Why:** Indicate who else was present and what else was occurring at the time of event. Document any possible causes that may have triggered the incident.

**Example:** No one else present. Attempting to leave bathroom. Floor was wet at doorway. Resident's shoes smooth on bottom and slick when wet.

**Initials:** Indicate initials of person completing the what/where/who/why portion of form.

**Intervention:** What changes were made to help the resident or to keep the event from occurring again.

Ask yourself and document when appropriate:

1. why intervention improves resident function
2. how intervention permits access to resident's own body
3. how intervention promotes highest level of resident functioning

**Example:** Non-skid tape added to floor at doorway. Resident's shoes evaluated for fit and found acceptable. Might consider adding handle bar at doorway if future incidences occur. Patient still able to safely toilet himself.

If intervention is for medical necessity, document what condition is present or treatment is necessary.

Document any time frames when device is to be used or discontinued.

**Assessment of Intervention:** Clearly document whether intervention was successful. If intervention was successful, state why. If intervention was not successful, state why it did not work and what will be tried next. Go on to next block on the form if more space is needed. Expect to try additional interventions until the least restrictive successful intervention is achieved.

**Example:** No falls in last 48 hours after non-skid tape placed on floor.

**Review and Comment by Charge Nurse/Restraint Committee:** Add initials and comments of charge personnel. State agreement, what to consider, or future plans with patient.

**Example:** Reviewed and approved by J. Smith, RN 7/22/97



# POSSIBLE AREAS FOR EVALUATION: **F A L L S**

**DO INTERDISCIPLINARY ASSESSMENT/SELECT BEST INTERVENTION**  
**CONSULT PRIMARY CARE PROVIDER, AS APPROPRIATE**

<b>FALLS</b>	<b>Physiological</b>	<b>Medication</b>	<ul style="list-style-type: none"> <li>◆ Dosage - multiple dosages/multiple medications</li> <li>◆ Check drug substitution, interactions, side effects of psychotropics, diuretics, cardiovascular</li> <li>◆ Have any new medications been added to regimen which may increase falls?</li> <li>◆ Tegretol level      ◆ Neurological checks      ◆ Frequent toileting assist if on diuretics</li> <li>◆ Dilantin level      ◆ Electrolytes, BUN, creatinine      ◆ Limit long-acting benzodiazapines</li> <li>◆ Depakote level      ◆ Void before tranquilizers/sedatives      ◆ Administer pain meds before transfer &amp; ROM</li> </ul>														
		<b>Unstable gait</b>	<ul style="list-style-type: none"> <li>◆ Restorative nursing program      ◆ Evaluate hearing and vision</li> <li>◆ Evaluate clothing for size &amp; length      ◆ Physical therapy--weight bearing</li> <li>◆ Gait training, muscle strengthening for ADL training      ◆ Walker, cane, merry walker</li> <li>◆ Fracture, arthritis, TIAs, seizures, Parkinson's, hypothyroidism, anemia      ◆ Shoe assessment</li> </ul>														
		<b>Cardiovascular insufficiency Syncope - orthostatic, TIA, arrhythmia, hypotension</b>	<ul style="list-style-type: none"> <li>◆ Auscultate sitting and walking      ◆ EKG, 24 hr. Holter monitor, O<sub>2</sub> saturation, CXR, electrolytes, BUN, creatinine, orthostatic BP, heart rate, digitalis level</li> <li>◆ Teach to change position slowly</li> <li>◆ Use elastic stockings      ◆ Check pacemaker</li> </ul>														
		<b>Infection</b>	<ul style="list-style-type: none"> <li>◆ Upper respiratory infection      ◆ Urinary tract infection</li> <li>◆ Fever - frequently afebrile, lung sounds, CBC, CXR, UA-C&amp;S, O<sub>2</sub> saturation</li> </ul>														
		<b>Hyperglycemia/Hypoglycemia</b>	<ul style="list-style-type: none"> <li>◆ Check blood sugar</li> </ul>														
		<b>Dehydration Constipation</b>	<ul style="list-style-type: none"> <li>◆ Provide 1.5 to 2 qts. of water per day unless otherwise restricted      ◆ Change in mental status</li> <li>◆ Check bowel sounds, abdominal distention, impaction</li> </ul>														
		<b>Pain</b>	<table border="1"> <tr> <td>◆ History of pain</td> <td>◆ Quality</td> <td>◆ Medications - try pain medications</td> <td>◆ Massage</td> </tr> <tr> <td>◆ Location</td> <td>◆ Onset, duration</td> <td>◆ Transcutaneous nerve stimulation</td> <td>◆ Heat</td> </tr> <tr> <td>◆ Intensity</td> <td>◆ Ability to express pain</td> <td>◆ Physical therapy</td> <td>◆ Cold</td> </tr> </table>	◆ History of pain	◆ Quality	◆ Medications - try pain medications	◆ Massage	◆ Location	◆ Onset, duration	◆ Transcutaneous nerve stimulation	◆ Heat	◆ Intensity	◆ Ability to express pain	◆ Physical therapy	◆ Cold		
		◆ History of pain	◆ Quality	◆ Medications - try pain medications	◆ Massage												
		◆ Location	◆ Onset, duration	◆ Transcutaneous nerve stimulation	◆ Heat												
		◆ Intensity	◆ Ability to express pain	◆ Physical therapy	◆ Cold												
<b>Sleep</b>	<table border="1"> <tr> <td>◆ Sleep/wake patterns</td> <td>◆ Diet effects</td> <td>◆ Maintain regular schedule</td> <td>◆ Deep gentle exercise</td> </tr> <tr> <td>◆ Bedtime routines/rituals</td> <td>◆ Physiologic</td> <td>◆ Limit caffeine, cigarettes, etc.</td> <td>◆ Avoid napping</td> </tr> <tr> <td>◆ Medications</td> <td>◆ Illness</td> <td>◆ Avoid hypnotics</td> <td>◆ Avoid stimulating drugs</td> </tr> <tr> <td></td> <td></td> <td>◆ Room - quiet, cool, no noise</td> <td></td> </tr> </table>	◆ Sleep/wake patterns	◆ Diet effects	◆ Maintain regular schedule	◆ Deep gentle exercise	◆ Bedtime routines/rituals	◆ Physiologic	◆ Limit caffeine, cigarettes, etc.	◆ Avoid napping	◆ Medications	◆ Illness	◆ Avoid hypnotics	◆ Avoid stimulating drugs			◆ Room - quiet, cool, no noise	
◆ Sleep/wake patterns	◆ Diet effects	◆ Maintain regular schedule	◆ Deep gentle exercise														
◆ Bedtime routines/rituals	◆ Physiologic	◆ Limit caffeine, cigarettes, etc.	◆ Avoid napping														
◆ Medications	◆ Illness	◆ Avoid hypnotics	◆ Avoid stimulating drugs														
		◆ Room - quiet, cool, no noise															
<b>Dementia/cognitive disorders Denial of impairment/depression</b>	<table border="1"> <tr> <td>◆ Attitude/approach</td> <td>◆ Distraction evaluation</td> <td>◆ Hearing/vision</td> <td>◆ Verbal approaches</td> </tr> <tr> <td>◆ Structured ADL schedules</td> <td>◆ Locate near nurses' station</td> <td>◆ Geriatric Depression Scale</td> <td></td> </tr> </table>	◆ Attitude/approach	◆ Distraction evaluation	◆ Hearing/vision	◆ Verbal approaches	◆ Structured ADL schedules	◆ Locate near nurses' station	◆ Geriatric Depression Scale									
◆ Attitude/approach	◆ Distraction evaluation	◆ Hearing/vision	◆ Verbal approaches														
◆ Structured ADL schedules	◆ Locate near nurses' station	◆ Geriatric Depression Scale															
<b>Physical surroundings</b>	<table border="1"> <tr> <td>◆ Bedrails</td> <td>◆ Bathroom</td> <td>◆ Noise</td> <td>◆ TV-remote control</td> <td>◆ Accessible call light</td> </tr> <tr> <td>◆ Furniture</td> <td>◆ Lighting</td> <td>◆ Floor</td> <td>◆ Stairs</td> <td></td> </tr> </table>	◆ Bedrails	◆ Bathroom	◆ Noise	◆ TV-remote control	◆ Accessible call light	◆ Furniture	◆ Lighting	◆ Floor	◆ Stairs							
◆ Bedrails	◆ Bathroom	◆ Noise	◆ TV-remote control	◆ Accessible call light													
◆ Furniture	◆ Lighting	◆ Floor	◆ Stairs														
<b>Family</b>	<ul style="list-style-type: none"> <li>◆ Involve family in care planning      ◆ Teach about current condition and interventions</li> <li>◆ Teach about predicted course of illness, as appropriate, behavior changes that result from cognitive loss</li> </ul>																

Adapted from *Rehabilitation Nursing*,  
 15 (1), 22-25, 1990, with permission from the Association of Rehabilitation Nurses.

# Assessment Log/ Intervention Care Plan

**Document: Initial Assessment/Each Event/Actions & Results**

		<b>Resident:</b>	<b>ID #:</b>	<b>Room #:</b>
		<b>Intervention</b>		<b>Assessment of Intervention</b>
		What did staff do? How does this improve resident function? Permits resident access to his/her own body? Least restrictive and highest level of functioning?		How did intervention work? If not, why? If yes, why?
<b>Event #</b>	<b>When</b> (Date/Time)			
<b>What/Where</b>	What behavior/event was observed? Where did it occur? (Be specific)			
<b>Who/Why</b>	Who else was present? What was happening? What may have caused or triggered behavior? _____			
		Review & Comment by Charge Nurse/Restraint Committee:		
		Initials		
<b>Event #</b>	<b>When</b> (Date/Time)			
<b>What/Where</b>	What behavior/event was observed? Where did it occur? (Be specific)			
<b>Who/Why</b>	Who else was present? What was happening? What may have caused or triggered behavior? _____			
		Review & Comment by Charge Nurse/Restraint Committee:		
		Initials		
<b>Event #</b>	<b>When</b> (Date/Time)			
<b>What/Where</b>	What behavior/event was observed? Where did it occur? (Be specific)			
<b>Who/Why</b>	Who else was present? What was happening? What may have caused or triggered behavior? _____			
		Review & Comment by Charge Nurse/Restraint Committee:		
		Initials		



# POSSIBLE AREAS FOR EVALUATION: BEHAVIOR PROBLEMS

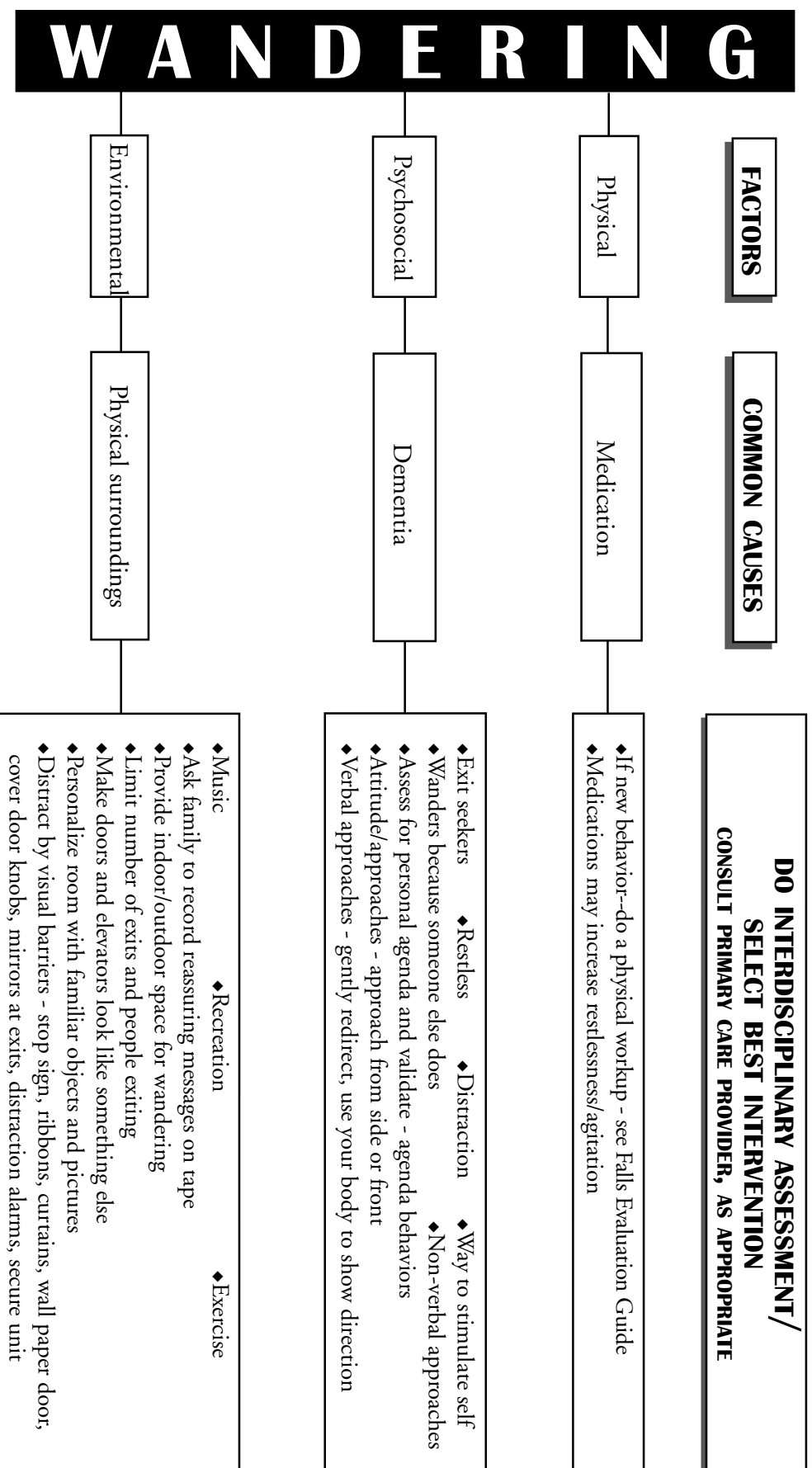
## BEHAVIOR PROBLEMS

FACTORS	COMMON CAUSES	DO INTERDISCIPLINARY ASSESSMENT/SELECT BEST INTERVEN- CONSULT PRIMARY CARE PROVIDER, AS APPROPRI-															
Physical	Medication	<ul style="list-style-type: none"> <li>◆ Dosage - multiple dosages/multiple medications</li> <li>◆ Check drug substitution, interactions, side effects of psychotropics, diuretics, cardiovascular</li> <li>◆ Have any new medications been added to regimen which may increase falls?</li> <li>◆ Tegretol level      ◆ Neurological checks      ◆ Frequent toileting assist if on diuretics</li> <li>◆ Dilantin level      ◆ Electrolytes, BUN, creatinine      ◆ Limit long-acting benzodiazapines</li> <li>◆ Depakote level      ◆ Void before tranquilizers/sedatives      ◆ Administer pain meds before transfer &amp; ROM</li> </ul>															
	Cardiovascular insufficiency Syncope - orthostatic, TIA, arrhythmia, hypotension	<ul style="list-style-type: none"> <li>◆ Auscultate sitting and walking      ◆ EKG, 24 hr. Holter monitor, O<sub>2</sub> saturation, CXR, electrolytes, BUN, creatinine, orthostatic BP, heart rate, digitalis level</li> <li>◆ Teach to change position slowly</li> <li>◆ Use elastic stockings      ◆ Check pacemaker</li> </ul>															
	Infection	<ul style="list-style-type: none"> <li>◆ Upper respiratory infection      ◆ Urinary tract infection</li> <li>◆ Fever - frequently afebrile, lung sounds, CBC, CXR, UA-C&amp;S, O<sub>2</sub> saturation</li> </ul>															
	Hyperglycemia/Hypoglycemia	<ul style="list-style-type: none"> <li>◆ Check blood sugar</li> </ul>															
	Dehydration Constipation	<ul style="list-style-type: none"> <li>◆ Provide 1.5 to 2 qts. of water per day unless otherwise restricted      ◆ Change in mental status</li> <li>◆ Check bowel sounds, abdominal distention, impaction</li> </ul>															
	Pain	<table border="1"> <tr> <td>◆ History of pain</td> <td>◆ Quality</td> <td>◆ Medications - try pain medications</td> <td>◆ Massage</td> </tr> <tr> <td>◆ Location</td> <td>◆ Onset, duration</td> <td>◆ Transcutaneous nerve stimulation</td> <td>◆ Heat</td> </tr> <tr> <td>◆ Intensity</td> <td>◆ Ability to express pain</td> <td>◆ Physical therapy</td> <td>◆ Cold</td> </tr> </table>	◆ History of pain	◆ Quality	◆ Medications - try pain medications	◆ Massage	◆ Location	◆ Onset, duration	◆ Transcutaneous nerve stimulation	◆ Heat	◆ Intensity	◆ Ability to express pain	◆ Physical therapy	◆ Cold			
	◆ History of pain	◆ Quality	◆ Medications - try pain medications	◆ Massage													
◆ Location	◆ Onset, duration	◆ Transcutaneous nerve stimulation	◆ Heat														
◆ Intensity	◆ Ability to express pain	◆ Physical therapy	◆ Cold														
Sleep	<table border="1"> <tr> <td>◆ Sleep/wake patterns</td> <td>◆ Diet effects</td> <td>◆ Maintain regular schedule</td> <td>◆ Deep gentle exercise</td> </tr> <tr> <td>◆ Bedtime routines/rituals</td> <td>◆ Physiologic</td> <td>◆ Limit caffeine, cigarettes, etc.</td> <td>◆ Avoid napping</td> </tr> <tr> <td></td> <td></td> <td>◆ Avoid hypnotics</td> <td>◆ Avoid stimulating drugs</td> </tr> <tr> <td></td> <td></td> <td>◆ Room - quiet, cool, no noise</td> <td></td> </tr> </table>	◆ Sleep/wake patterns	◆ Diet effects	◆ Maintain regular schedule	◆ Deep gentle exercise	◆ Bedtime routines/rituals	◆ Physiologic	◆ Limit caffeine, cigarettes, etc.	◆ Avoid napping			◆ Avoid hypnotics	◆ Avoid stimulating drugs			◆ Room - quiet, cool, no noise	
◆ Sleep/wake patterns	◆ Diet effects	◆ Maintain regular schedule	◆ Deep gentle exercise														
◆ Bedtime routines/rituals	◆ Physiologic	◆ Limit caffeine, cigarettes, etc.	◆ Avoid napping														
		◆ Avoid hypnotics	◆ Avoid stimulating drugs														
		◆ Room - quiet, cool, no noise															
Psychosocial	Delusions Hallucinations Depression	<ul style="list-style-type: none"> <li>◆ Assess aggressive behavior      ◆ Contract with patient      ◆ Behavior modification</li> <li>◆ Assess psychoactive medications      ◆ Cognitive therapy</li> </ul>															
	Dementia Alzheimer's Disease	<ul style="list-style-type: none"> <li>◆ Attitude/approach - calm, flexible, guiding (not controlling)</li> <li>◆ Verbal approaches - concrete, validate feeling, task segmentation, avoid excess disability</li> <li>◆ Non-verbal approaches - attitude contagious, equal/lower position, therapeutic touch</li> <li>◆ Music therapy      ◆ Distraction therapy      ◆ Recreation      ◆ Exercise      ◆ Remotivation</li> </ul>															
Environmental	Physical surroundings	<ul style="list-style-type: none"> <li>◆ Call light      ◆ Rocking chair      ◆ Night-time activities      ◆ Avoid sensory overload</li> <li>◆ Roommate      ◆ Personalize room      ◆ Assess interpersonal preferences</li> <li>◆ Staff: street clothes, decrease turnover, resident chooses caregiver, permanent assignments, use non-nursing as much as possible, consistent scheduling</li> </ul>															

Adapted from *Rehabilitation Nursing*, 15 (1), 22-25, 1990, with permission from the Association of Rehabilitation Nurses.

Colorado Foundation for Medical Care - Funding provided by HCFA Contract #500-96-P611

## POSSIBLE AREAS FOR EVALUATION: **WANDERING**



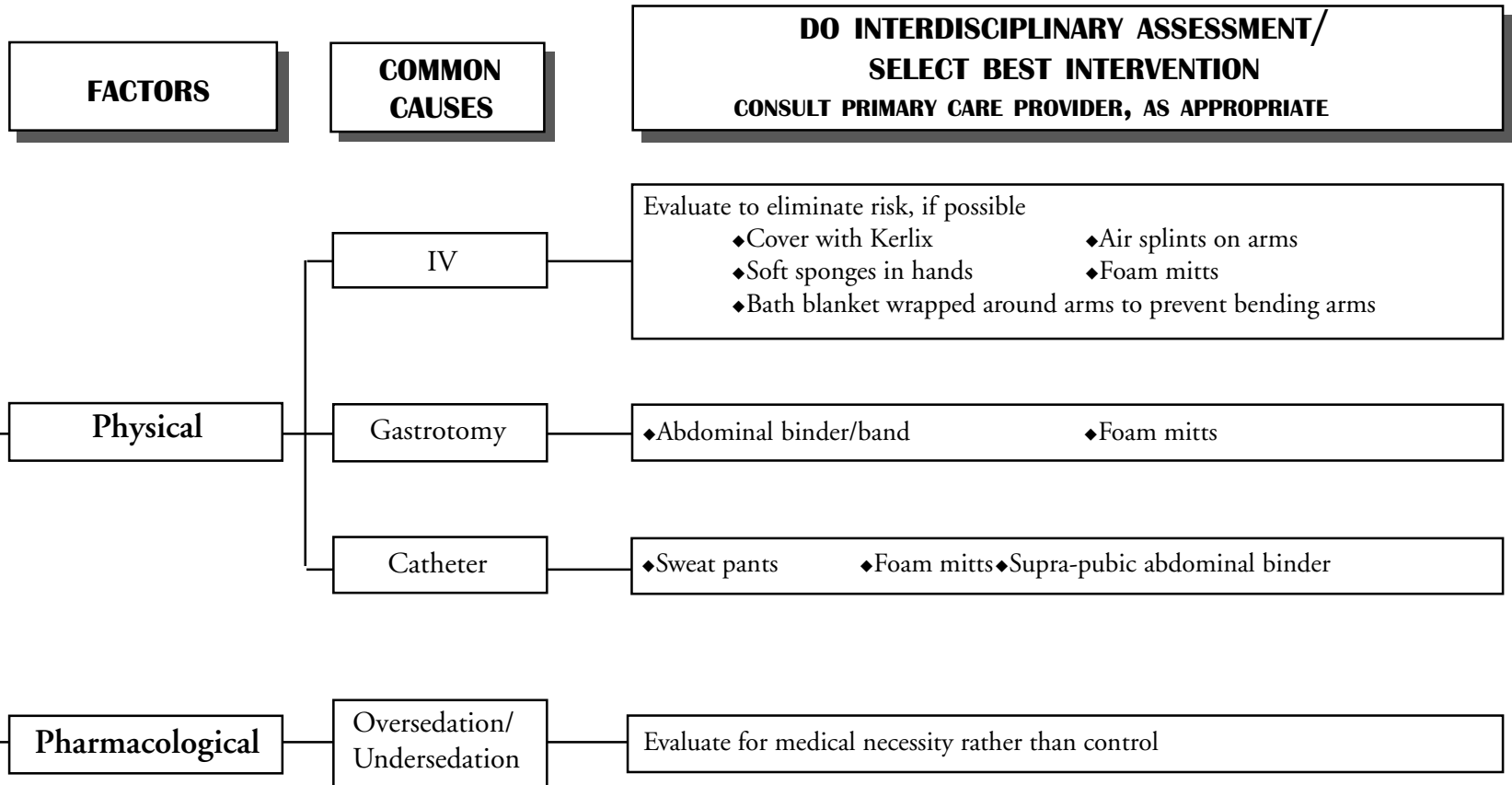
Adapted from *Rehabilitation Nursing*, 15 (1), 22-25, 1990,  
with permission from the Association of Rehabilitation Nurses.

Colorado Foundation for Medical Care  
Funding provided by HCFA Contract #500-96-P611

# MEDICAL NECESSITY

## POSSIBLE AREAS FOR EVALUATION:

# MEDICAL NECESSITY



Adapted from *Rehabilitation Nursing*, 15 (1), 22-25, 1990,  
with permission from the Association of Rehabilitation Nurses.

Colorado Foundation for Medical Care  
Funding provided by HCFA Contract #500-96-P611

# FALLS

***FIRST COMPLETE BASIC ASSESSMENT TO RULE OUT MEDICAL ILLNESS BEFORE PROCEEDING WITH THIS SECTION.***

## Medications

### **DOSAGE - MULTIPLE DOSAGES/MULTIPLE MEDICATIONS**

- Seniors usually require 1/2 - 2/3 of the normal dose especially there is a hepatic/renal disease, low body weight, and malnutrition.

### **CHECK DRUG SUBSTITUTIONS, INTERACTION, SIDE EFFECTS - psychotropics, diuretics, cardiovascular**

- Be aware that for institutionalized individuals the greater risk of falls is in the first six weeks, however, the risk remains somewhat higher for the first six months.
- Evaluate medications for drug toxicity
- Some residents may be toxic at therapeutic levels, while other residents may be at therapeutic levels when medication is below usual accepted range.
- Psychotropics
  - Recommend to physician avoidance of long-acting barbiturates and benzodiazepines and limit other sedatives/tranquilizers if indicated, for example PRN.
  - Have residents void before receiving tranquilizers/sedatives
  - Do not hold back medication if physician feels it is indicated. Depression and psychosis are as real as physically observed disabilities.
- Diuretics
  - Offer frequent toileting assistance if diuretics are used
  - Minimize use of diuretics at bedtime
  - May cause hypotension
  - Will require electrolytes, BUN, and creatinine at least every 6 months to monitor renal status
- Cardiovascular
  - Monitor residents for orthostatic dizziness
  - Watch for signs of weakness or fatigue - taking anti-hypertensives?
  - Many cardiac medications after Heart Rate.
  - Teach resident to rise slowly from a sitting or lying position

### **HAVE ANY MEDICATIONS BEEN ADDED TO REGIMEN WHICH MAY INCREASE FALLS?**

- Benzodiazepine, psychotropics, anti-convulsants/mood stabilizers, cardiovascular meds

## **DIGITALIS LEVELS**

- Heart rate that is dramatically fast or slow decreases the efficiency of the heart resulting in hypoxia to vital organs including the brain.

## **DILANTIN™ LEVEL VPA(VALPROIC ACID) TEGRETOL™**

- May cause sedation and dizziness even at therapeutic levels. Disorientation may be experienced as well as nausea. These medications require CBC and liver function tests every 6 months.

## **SMA 6 (BLOOD CHEMISTRY PANEL)**

- Elevated BUN with creatinine may indicate renal failure or dehydration. Electrolytes (Na, K, Cl) are important in muscle contractibility - includes the cardiac muscle

## **VOID BEFORE GIVING TRANQUILIZERS / SEDATIVES**

## **FREQUENT TOILETING ASSIST IF ON DIURETICS**

## **LIMIT LONG-ACTING BENZODIAZEPINES**

- When possible, Ativan™ is a popular short-acting benzodiazepine.

## **ADMINISTER PAIN MEDICATIONS BEFORE ROM AND TRANSFER**

- Non-Steroidal Anti-Inflammatory drugs are useful, but these drugs continue to have a higher incidence of gastrointestinal, hepatic and renal side effects. An acetaminophen may be a better choice for osteoarthritis. Use adequate pain meds to include narcotics in proper dose. Addiction is not an issue in this population. Be watchful for sedation and CONSTIPATION.

# **Unstable Gait**

## **RESTORATIVE NURSING PROGRAM**

- Gait training including small steps and broad base stance
- Balance exercises, including standing on one foot, reaching and turning while sitting and picking up objects
- Talk with resident about limitations related to mobility
- Teach difference in transfer with right vs. left sided stroke, difference in ambulation with a resident with Parkinson's vs. resident who has had a stroke
- Work with physical therapist to design good restorative nursing program
- Devices which assist with reaching or placing items within reach
- Extra pillows for positioning

## **EVALUATE CLOTHING SIZE AND LENGTH**

- Clothing
  - Proper fitting clothing
    - No long robes
    - Clothing which slips on instead of over the head or step in
    - Hemmed trousers, with belts to prevent drooping
    - Is clothing appropriate for weather?

- Cognitively disabled (psychosis) frequently have an altered sense of body temperature resulting in their wearing winter coats in 90° weather.

## **GAIT TRAINING, MUSCLE STRENGTHENING FOR ACTIVITIES OF DAILY LIVING TRAINING**

### **FRACTURE**

- Residents with osteoporosis may fracture bones while turning over in bed. Suspect fracture whenever there is a trauma or if there are any new complaints of severe pain in a bony area, especially if they cannot bear weight.
- Arthritis
  - Usually of the Degenerative Joint Disease, Osteoarthritis type - Acetaminophen or mild narcotic that is effective.
- Transient Ischemic Attacks
  - Results in neuro deficits that usually resolve in a few hours - days
- Seizures
  - Check level of seizure med and for infections. If this is a new onset, deserves physical work up to include EEG and brain scan if appropriate
- Parkinson's Disease
  - Results in motor neural dysfunction. Extremities may become very rigid, gait; short and shuffling. Sense of balance is effected. Disease or medication may cause dementia and/or hallucinations.
- Hypothyroidism
  - Can dramatically slow body processes, to include motor and cognitive
- Anemia
  - If RBCs are low, O<sub>2</sub> may not be adequately reaching cells. An O<sub>2</sub> sat may read normal even when hypoxia exists. A pulse Ox measures what percentage of RBCs are saturated with O<sub>2</sub>. If there is an inadequate amount of RBCs, they can be 100% saturated but there is still inadequate oxygen.

### **EVALUATE HEARING AND VISION**

- Assessment of hearing and vision - Residents with impaired hearing and/or vision may appear to have mental status problems when this is not the case
  - Hearing - Has hearing been checked recently? Does the resident need a hearing aid? If the resident has a hearing aid, does it function properly? Does the resident have a problem with excessive ear wax?
  - Vision - Does the resident have history of cataracts? Have glasses been checked in the past year? Are glasses in good repair? Are they cleaned daily?

### **PHYSICAL THERAPY - WEIGHT BEARING**

- Evaluation by P.T. and O.T.
  - Exercised aimed at increasing muscle strength, coordination, or dexterity
  - Get occupational therapy to evaluate for Activities of Daily Living training



- Have P.T. evaluate how resident can move in least painful way to increase strength and mobility

#### **WALKER, CANE, MERRY WALKER™**

- Are walker, wheelchair, etc. appropriate for problem
- Non-skid tips on canes and walkers
- Instruction in use of devices
- Teach the resident how to use wheelchairs, crutches, walkers and canes safely, teach frequently if the resident is forgetful.
- Use reflective tape on cane and walker handles.

#### **SHOE ASSESSMENT**

- Educate resident and family about proper footwear
- Non-skid shoes for residents likely to slip
- Shoes with a smoother surface for residents with Parkinson's Disease due to shuffling gait
- Make certain shoes fit well
- Podiatry referral if special shoes required
- Shoes require an adequate back and toe box

### **CARDIOVASCULAR INSUFFICIENCY - Syncope, Orthostatic, TIA, Arrhythmia, Hypertension**

#### **AUSCULTATE SITTING AND WALKING**

- A resident may have a normal sinus rhythm when sitting yet go into an arrhythmia with movement resulting in hypoxia

#### **TEACH TO CHANGE POSITION SLOWLY**

#### **USE OF ELASTIC STOCKINGS**

- Use when lack of patency of lower extremity circulatory system exists. Are their pedal pulses, sensation intact?

#### **EKG**

- Gives a cardiac reading at time of test

#### **24 HOUR HALTER - MONITOR**

- Can show cardiac reaction to 24<sup>o</sup> of activity and stimulus

#### **O<sub>2</sub> SATURATION**

- Important to check with any change in mental or physical condition. Increased frequency of respiration can cause a misleading reading as can anemia.

#### **CXR (Chest X-Ray)**

- May be indicated in change of mental or physical condition. Pneumonia is very common in LTC population. If CHF is noted on X-ray, it is probably advanced. There may be no rales, rhonchi accompanying an infiltrate.

### **SMA6 (Blood Chemistry Panel)**

- Measures renal status and may indicate dehydration. Electrolytes (Na, K, Cl) are necessary for muscle contractibility, including the heart muscle.

### **ORTHOSTATIC BP**

- May check by doing blood pressure and heart rate while lying, sitting and standing. This must be done in this order and with a 1 minute wait period between each reading.
- Gradually increase mobility after confinement to bed or chair to prevent falls due to orthostatic hypotension

### **HEART RATE**

- Heart rate that is dramatically fast or slow decreases the efficiency of the heart resulting in hypoxia to vital organs including the brain.

### **CHECK PACEMAKER**

- Yearly evaluation

## **Infection**

### **UPPER RESPIRATORY INFECTION**

- Seniors have fewer colds, sinusitis and otitis media than the young, yet they do occur. Suggest that facility have at least one ophthalmoscope with staff trained to assess using this tool.

### **FEVER - FREQUENTLY AFEBRILE**

- Least reliable of vital signs when assessing the elderly. They can be septic while afebrile.
- Lung Sounds
  - Many elderly have decreased breath sounds due to lung disease, smoking, etc. This may be their baseline. It is wise to compare what you are hearing with what has been heard in the past. A senior may have no rales - cough or wheezing and still have pneumonia.
- CBC
  - These are important in assessing the immune system and in checking for anemia.
- CXR ( Chest X-Ray)
  - May show infiltrates, CHF and other pulmonary disease. Portable x-ray is not as reliable as large x-ray, particularly when x-raying areas of greater density
- UA - C&S (URINE ANALYSIS - CULTURE AND SENSITIVITY)
  - FIRST TEST TO DO WHEN THERE IS A CHANGE OF MENTAL PHYSICAL CONDITION OF UNKNOWN ETIOLOGY. ELDERLY MAY HAVE NO PHYSICAL SYMPTOMS. BACTERIA IN URINE WITHOUT WBCs ARE NOT USUALLY SIGNIFICANT - RESULT OF CONTAMINATION.

- O<sub>2</sub> Saturation
  - As previously, may be false positive if resident is hyperventilating or anemic. This is a very useful tool in assessing cardiac/pulmonary status.

### **URINARY TRACT INFECTION**

- Most common cause of physical or mental change. Usually caused by urinary retention, catheters, poor hygiene.

## **Hypoglycemia**

### **CHECK BLOOD SUGAR**

- Hypoglycemia can cause deterioration in motor/neural/cognition - may become lethargic and confused because brain is receiving inadequate glucose

## **Dehydration**

### **NEEDS 1.5 TO 2 QUARTS OF WATER PER DAY unless otherwise restricted**

- Common problem in LTC. Thirst mechanisms may be impaired by disease. Resident may have impaired motor abilities and be unable to reach water in his environment. High use of diuretics, while necessary, contribute to dehydration, as does swallowing dysfunction.

## **Constipation**

### **CHECK BOWEL SOUNDS**

- Listen for at least 2 minutes in each quadrant before deciding there are no bowel sounds

### **ABDOMINAL DISTENTION - Coffee Ground Emesis**

- Distention may indicate an obstruction, renal, hepatic or biliary disease. Coffee ground emesis indicates a GI bleed.

### **IMPACTION**

- If low, may be removed manually with care. Higher up impactions are only identified by x-ray and require laxatives and fluids.

### **CHANGE IN MENTAL STATUS**

- May be caused by meds or illness - UTI and pneumonia most common medical problem.

# Pain

## INITIAL PAIN ASSESSMENT

- Pain is whatever the experiencing person says it is. The individual's perception of pain is a unique experience that includes the variables of the patient's culture, gender, past pain experience, meaning attached to pain, and physiologic alterations, including those due to aging.
- Studies have found nurses and doctors do not ask patients "Are you in pain?" Even very demented residents may respond to simple straight forward questions. This should be a routine question in any assessment. Cognitively disabled may not be able to express pain in accepted ways. Agitation, yelling may be the only clue.
  - The fear of addiction remains common among patients, family members, physicians, and nurses despite large studies indicating the risk is less than 1%. Concerns should be sedation interfering with activities of daily living (most people develop tolerance) and constipation.
- Intractable pain
  - Assess the patient's pain and believe his assessment of the pain. Pain is a subjective experience rather than an objective experience.
  - Give analgesics (pain medication) in doses high enough and frequent enough to control the pain.
  - Treat the pain before it returns. This involves maintaining constant blood levels of the analgesic at all times and is achieved by giving the medication around the clock rather than "PRN". (Cushing, 1992)
- Demographics and General Information on Pain in Nursing Home Residents: (Fried, 1993)
  - Pain is frequently associated with depression. Depression is most common in residents who have physical disorders which cause pain. Chronic pain is sometimes relieved by addition of low dose anti-depressants in conjunction with analgesic.
  - Only 40 to 45% of residents who reported pain in studies have it noted on their charts.
  - For resident who are severely demented, there is even less documentation of or treatment for pain. Care providers are forced to rely on pain behaviors such as fidgeting, facial grimacing and irritability. However, the accuracy of pain rating based on these observations is unknown.

## Behaviors Associated with Pain:

Type of Behavior	Examples
Facial expression	Grimacing, clenching teeth, tightly shutting lips, gazing/staring, wrinkling forehead, tearing
Vocalization	Moaning, groaning, grunting, sighing, gasping, crying, screaming
Verbalization	Praying, counting, swearing or cursing, repeating nonsensical phrases
Body action	Thrashing, pounding, biting, rocking, rubbing
Behaviors	Massaging, immobilizing, guarding, bracing, eating/drinking, applying pressure/heat/cold, assuming special position/posture, reading, watching television, listening to music

From Puntillo, K., & Wilkie, D. (1991). Assessment of pain in the critically ill. In K. Puntillo (Ed.), *Pain in the critically ill: Assessment and management*. Gaithersburg, MD: Aspen. Reprinted by permission.

## Sleep

### ASSESSMENT OF SLEEP

- Nature of sleep problem including characteristics, clinical course, its duration, the circumstances under which it developed, any precipitating or accentuating factors, any previous treatment and results, and the impact of the sleep problem on resident's life.
- Usual sleep-wake pattern for 24 hours - as we age, our sleep pattern changes. Seniors typically do not sleep as long, wake sooner and more frequently, than when they were younger. Assure them this may be normal.
- Bedtime rituals/routines and environmental factors - noise, temperature
- Diet and drug use (both prescription and over the counter) - including usual intake of caffeine (coffee or cola) or alcohol. Excessive use of alcohol leads to difficulty in staying asleep. Withdrawal of relatively low doses of short or intermediate-acting benzodiazepines produce rebound insomnia and abrupt withdrawal of long acting benzodiazepine hypnotics may cause both insomnia and nightmares. Insomnia is aggravated by stimulant drugs, steroids, energizing anti-depressants or beta-adrenergic blockers. These drugs cause sleep problems if taken at bedtime.
- Illness factors - Changes in health, including Alzheimer's disease, cardiovascular disease, pulmonary disease, arthritis, pain, prostatic disease, endocrinopathies, and other illnesses.
- Objective Data - Family and significant others may provide insight into usual patterns and certain aspects of sleep. Resident may have a diagnosis of being a "night" person who sleeps during the day.
- Subjective - Many short sleepers who do not complain of insomnia actually sleep much less than most insomniacs, but while short sleepers feel rested and alert on awakening in the morning, most insomniacs feel tired and sluggish. The patient's complaint of insomnia, rather than the actual amount of sleep, is the criterion for diagnosis. Health care providers should not be biased by own sleep habits.
  - Listen to verbal comments of not sleeping well, of not feeling rested, of being tired, of being awakened earlier than usual, or of having interrupted sleep or being more irritable, restless, lethargic, a greater sensitivity to pain, an increase in accidents and falls.
- Changes in emotional life - stressors such as retirement, hospitalization or the death of a loved one.
- Chronic insomniacs generally show high levels of psychopathology and a tendency to internalize emotional conflicts, which leads to psychophysiologic activation and a state of hyperarousal. Acute insomnia is also common in many psychiatric conditions, including depression, anxiety disorder, mania, acute schizophrenia and organic brain syndrome or other psychiatric illness. The insomniac patient may use his symptoms for considerable secondary gain. It is not unusual for insomniacs to avoid family and social interactions by insisting they are too tired or by protesting that a certain activity will adversely affect their sleep. May be used to avoid sexual relations.

- Treatment depends on type of sleep difficulty and its etiology. If the difficulty is in falling asleep, the focus should be on pre-sleep routine and his mental activity while attempting to fall asleep. If the complain is difficulty staying asleep, the possibility of medical problems or unsatisfactory environmental conditions should be investigated. Early final awakenings are often symptomatic of endogenous depression and warrant inquiry about other depressive symptoms.
- Assessment of pain - If pain predominates, analgesic agents should be used to their maximum therapeutic benefit.
- Fear of death: Patients who are seriously ill have a greater fear of death at bedtime, and frequently have severe difficulty getting to sleep. Patients with asthma, COPD or CHF often experience disrupted sleep because they fear the recurrence of symptoms during sleep.

#### **TREATMENT OF COMMON DISORDERS:**

- Adjustment Sleep Disorder:
  - It arises in fair to good sleepers who are coping with recent stressors such as retirement, hospitalization, or death of a loved one. Usually will resolve with time as person adapts to stress-related event.
  - Problems with onset or maintenance of sleep result in daytime irritability, anxiety, lethargy, slowed cognition, and tearfulness. Often, worry and concern about sleeplessness create a level of arousal that is incompatible with sleep.
  - Treatment is more often needed in individuals with few sources of emotional support. Behavioral treatment is preferred. Treatment seeks to restore normal sleep. Relaxation tapes, proper sleep hygiene, self-help books such as No More Sleepless Nights.
  - Hypnotics are indicated if the patient is overwhelmed by the situation. However, they should only be administered for a few days or weeks.
  - Psychophysiological Insomnia: Usually develops after an adjustment disorder has developed and is combined with poor sleep hygiene. Older adults with psychophysiological insomnia associate their bed and bedtime rituals with frustration and increased mental and physical arousal. The sleep disturbance continues as a result of conditioned, learned arousal, even after normal coping and sleep habits are re-established. Two behavioral therapies are effective:
    - a. Stimulus Control Therapy: Used when sleep onset is the problem. If the patient does not go to sleep in 10 minutes or less, he is instructed to get up and then return to bed only when feeling sleepy again, repeating this pattern until sleep onset occurs quickly. This establishes a new habit of good sleep.
    - b. Sleep Restriction Therapy: Recommended when sleep maintenance is presenting problem. Average number of hours of sleep is determined. Then the patient is allowed to spend only this amount of time in bed. As sleep improves, the patient is allowed to retire 15 minutes earlier. This method consolidated the amount of sleep, leading to deeper sleep, faster onset, and fewer awakenings.

- Inadequate Sleep Hygiene: Irregular or poor sleep habits and sleep-incompatible behaviors constitute inadequate sleep hygiene.
  - Maintain a regular sleep schedule with a regular arising time. Irregular habits around the time they go to bed and rise can lead to sleep problems. Patients with poor sleep hygiene often spend excessive time in bed trying to sleep or follow highly irregular schedules for going to sleep and arising. Such practices deprive them of strong behavioral cues for deep, refreshing sleep.
  - Factors that heighten arousal include caffeine, cigarettes, alcohol withdrawal, working until bedtime, and clock watching may forestall sleep. They are preoccupied with their inability to sleep.
  - Hypnotics are best avoided because patients have increased risk of tolerance and continued sleep disruption from sleep-disruptive behaviors.
  - Make certain bedroom is quiet, comfortable, cool and secure. Decrease noise, the appropriate strategy would be to reduce the frequency of interruptions to sleep. Avoid caffeine after 12 o'clock noon.
  - Avoid napping during the day.
  - Get regular and gentle exercise around midday. Patients with insomnia often report low or inconsistent levels of physical activity during the day. Increase exercise, however, limit physical exercise or stimulating mental activity close to bedtime. This may also contribute to difficulty falling asleep.
  - Bed partner can often give useful information in assessing difficulties related to disordered schedules and routines. Especially myoclonus nocturnus (jerking movement of legs) and "restless legs syndrome".
  - Abstain from stimulating drugs (caffeine or decongestants) in the evening. Many over the counter sleep remedies contain anti-histamines which will actually worsen the sleep condition over time.
  - Avoid heavy meals or hunger at bedtime.
  - Get out of bed if awake. Limit time in bed to intimacy or sleep. Do not watch TV and read in bed. Restrict total time in bed to 6.5 to 7.5 hours. per day.
  - Avoid worry or frustration in bed. Schedule time to wind down and relax before going to bed.
  - Habitual pre-sleep activity that is comforting to the individual and enhances sleep. Pre-sleep activity for men tended to include food, drink, television, and walking. Pre-sleep activity for women tends to include hygienic activities, prayer, reading, and listening to music and watching TV. Sleep was more satisfying for those who followed a routine.

- Mood Disorders:
  - Alteration in sleep is the hallmark symptom of such psychiatric disorders as major depression, mania, dysthymic disorder, and cyclothymic disorder. Major depression, in particular, may disrupt an elderly person's ability to fall asleep, stay asleep, or both. Manics may not sleep for days at a time.
  - Often difficult, but important, to determine which came first insomnia or depression.
  - Treatment is warranted when depression is suspected.
  - Before antidepressants are prescribed, all depressed elderly should be screened for other causes of insomnia, particularly restless leg syndrome and myoclonus because antidepressants may worsen these syndromes, further disrupting the patients' sleep and mood.
  - Medical Illness and Treatment: One study found that 12 of 26 standing orders in a hospital included doses of hypnotic that are twice the recommended dosage for the elderly and often provide inappropriate repeat doses.
  - Physician's efforts to medicate underlying disease processes may result in sleep disruption. The most significant offenders are steroids, thyroxine, theophylline, and many centrally active antihypertensives.
  - Insomnia secondary to symptoms of medical illness is best managed by treating the underlying medical disorder. If pain predominates, narcotics and NSAIDs for bone pain or inflammatory conditions should be administered to their maximum therapeutic benefit.
- Dementia/Delirium:
  - Sleep disturbances in patients with dementing illness range from increased awakenings and nocturnal wanderings to agitation and confusion. "Sundowning" frequently leads to placement in an institution.
  - The changes in sleep in patients with dementia arise from degeneration of cortical and brain stem structures, resulting in poor accommodation to the transitions from sleep to wake and lighter, more broken sleep.
  - Treatment: Management of underlying metabolic, neurologic, or infectious processes. Behavioral management includes proper sleep hygiene, particularly exposure to morning light. Safety at night includes a night light and putting the mattress on the floor and removing glass objects.
  - When dementia is accompanied by agitation, low-dose antipsychotic medications may work. However, antipsychotics carry the risk of bradykinesia, rigidity, and tardive dyskinesias. Short acting Benzodiazepine or antidepressants such as trazodone should be tried and titrated to optimal dose; if not affective, then a trial of low dose antipsychotics may be tried.



- Sundowning
  - Occurs in patients with organic brain dysfunction. The classic symptoms are daytime drowsiness combined with nighttime confusion, agitation, and anxiety. At night residents tend to wander, exhibit speech and behavior that are not of character. Patients have a strong need to maintain contact with a familiar environment. They feel that their fading cognitive abilities are enhanced during the daytime. At night, however, they feel less safe and confident, and staying awake makes them feel more secure. Underlying environmental or organic factors that could cause sundown syndrome should first be ruled out. Such causes are easily treated. Simple environmental orientation procedures may help - keeping a light on in the bathroom. Medications include Haldol or Trazodone to reduce agitation, anxiety, and wandering and allow them to sleep. Hypnotics are contraindicated because they may cause patients to become more disoriented and confused. Paradoxically, these medications will excite already disinhibited patients. The patient's drug regimen should be evaluated for its potential to produce some or all of the symptoms of sundown syndrome. Medications that have an anticholinergic component, such as antidepressants, antihistamines, antiparkinsonism drugs, and antispasmodics, are particularly likely to have this effect. Non-essential drugs should be reduced or stopped.
  
- Prescribing Guidelines for Hypnotic:
  - Should be the intervention of last resort, use the lowest effective dose. Use half of the adult dose in patients over age 65.
  - Monitor for side effects. Check interaction of hypnotic with alcohol or drugs, and other interactions with lung or heart disease, Central Nervous System disease. Check for interaction with other medications such as Tagamet <sup>TM</sup>, phenobarbital and Dilantin <sup>TM</sup>.
  - Dispense a limited number of doses (#20) and follow for cognitive or behavioral changes.
  - If the medication is needed for more than two weeks, consider a maximum of three doses per week to lessen the chance of tolerance.
  - Selection of an appropriate hypnotic depends on the target symptoms, whether related to sleep onset, sleep maintenance, daytime anxiety, or possible depression.
  - Consider adverse effects on the patient with lung or heart disease, Central Nervous System disease, or a history of alcohol abuse.

## Denial of Impairment/Depression:

- Demented patients may deny or no longer realize that they cannot walk independently. They may refuse or forget to use their ambulatory device (wheelchair, walker), resulting in falls.
- In early to moderate dementia, residents may avoid answering questions or change the subject to disguise the fact that they cannot retrieve the information requested. "How old are you Mrs. Greene?" -- "As old as the hills," followed by smiles and laughter.
- It is very depressing to realize that you are losing your cognitive skills, your independence, your privacy, indeed your life.
- In view of the effective therapies available for depression, it is especially crucial to make the diagnosis and proceed with treatment.

### Drugs that can cause symptoms of depression

#### Antihypertensives

Reserpine  
Methyldopa  
Propranolol  
Clonidine  
Hydralazine  
Guanethidine

#### Analgesics

Narcotic  
Morphine  
Codeine  
Meperidine  
Pentazocine  
Propoxyphene

Nonnarcotic  
Indomethacin

#### Antiparkinsonism drugs

Levodopa

#### Antimicrobials

Sulfonamides  
Isoniazid

#### Cardiovascular preparations

Digitalis  
Diuretics  
Lidocaine

#### Hypoglycemic agents

#### Psychotropic agents

Sedatives  
Barbiturates  
Benzodiazepines  
Meprobamate

#### Antipsychotics

Chlorpromazine  
Haloperidol  
Thiothixene

#### Hypnotics

Chloral hydrate  
Flurazepam

#### Steroids

Corticosteroids  
Estrogens

#### Others

Cimetidine  
Cancer chemotherapeutic agents  
Alcohol

### Predisposition

1. Biological
  - family history of depression
  - prior episodes of depression
  - aging changes in neurotransmission
2. Physical
  - Many diseases can directly cause major depression or elicit a depressive reaction. This is particularly true of conditions that cause fear, produce chronic pain, disability or dependence, e.g., Dementia's, Parkinson's, suspected or possible MI, suspected or possible CVA - (right hemisphere infarcts more than left hemisphere) CHF, neoplasms, thyroid, adrenal cancers, diabetes, anemia, hypoxia and dehydration.
  - Drugs used to treat medical conditions can cause symptoms of depression
  - Some disease can result in a physical appearance of depression when depression does not exist, e.g., Parkinson.
3. Psychological
  - unresolved conflicts and guilt; symptomology more common in younger populations.
4. Social
  - loss of family, friends, independence, health, dignity, control and on and on; isolation, environmental factors that promote isolation, sensory deprivation and forced dependency.

### Recognition/Diagnosis

1. Classic neuro-vegetative signs - this is a general statement; the elderly have increased physical complaints and a decreased incidence of guilt or self worth issues. An explanation of this may be that the elderly are more comfortable with physical complaints than they are with psychological issues. Geriatric patients may expect a moralistic judgment regarding psych complaints and may not be familiar with the existence of treatment modalities.
  - Helpful mnemonic is Sig: E Caps
  - Sleep - c/o of insomnia with frequent early a.m. awakenings  
Hypersomnia
  - Interest - loss of interest in social connections  
isolation in room  
apathy
  - Guilt - feelings of self reproach - less common in elderly
  - Energy - no energy; fatigued - this may be due to chronic illness
  - Concentration - inability to concentrate or slowed, mixed up thought
  - Appetite - poor appetite, weight loss; sometimes present with overeating
  - Psychomotor - usually slowed, but agitation is very common and may be the only clear cut symptom in the elderly demented patient
  - Somatic complaints rather than psychological symptoms often predominate the clinical picture. Chronic pain is an important clue.
2. Major depression vs. depressive symptoms.
  - Depressive symptoms which is a gray area may also deserve chemical therapy.

### Differential Diagnosis

1. Rule out physical illness or treat existing illness.
2. Dementia vs. depression
  - frequently coexist. Depression is the main treatable cause of dementia in the elderly.

### Diagnostic criteria for major depressive episode

- A. At least five of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. (Do not include symptoms that are clearly due to a physical condition, mood-incongruent delusions or hallucinations, incoherence, or marked loosening of associations)
1. Depressed mood most of the day, nearly every day, as indicated either by subjective account or observation by others
  2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation by others of apathy most of the time)
  3. Significant weight loss or weight gain when not dieting (e.g., >5% of body weight in a month), or decrease or increase in appetite nearly every day
  4. Insomnia or hypersomnia nearly every day
  5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
  6. Fatigue or loss of energy nearly every day
  7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
  8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
  9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- B.1. Cannot be established that an organic factor initiated and maintained the disturbance.
2. Disturbance not a normal reaction to the death of a loved one (uncomplicated bereavement)<sup>1</sup>
- C. At no time during the disturbance have there been delusions or hallucinations for as long as two weeks in the absence of prominent mood symptoms (i.e., before the mood symptoms developed or after they have remitted).
- D. Not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder.

---

<sup>1</sup> Morbid preoccupation with worthlessness, suicidal ideation, marked functional impairment of psychomotor retardation, or prolonged duration suggest bereavement complicated by major depression.  
Source: After American Psychiatric Association, 1987.

**Table 5-15 Characteristics of selected antidepressant drugs**

Drug	Level of sedation	Anticholinergic activity	Usual young-adult dosage, mg/day	Recommended geriatric dosages, mg/day <sup>a</sup>	Elimination half-life <sup>b</sup>
Tricyclic tertiary amines					
Amitriptyline (Elavil, Endep, Amitril, etc.)	Very high	Very high	100-300	25-150	Intermediate
Doxepine (Sinequan, Adapin)	High	High	100-300	25-150	Intermediate
Imipramine (Tofranil, SK-Pramine)	Middle	Middle	100-300	25-150	Long
Tricyclic secondary amines					
Desipramine (Norpramin, Pertofrane)	None	Low	100-300	25-150	Long
Proliprypyline (Vivactil)	None	Middle	20-70	5-30	Very long
Nortriptyline (Aventyl, Parnelor)	Low	Middle	25-100	10-35	Long
Other amines					
Amoxapine (Asendin)	Middle	Middle	100-300	25-150	Intermediate
Maprotiline (Ludiomil)	Middle	Middle	100-300	25-150	Very long
Other drugs					
Trazodone (Desyrel)	Middle	Very low	150-400	50-200	Short
Fluoxetine (Prozac)	Very low	Very low	20-80	10-40	Very long
Sertraline (Zoloft)	Very low	Very low	50-200	25-100	Very long

*Note:* Other antidepressant drugs are disclosed in the text.

<sup>a</sup>Some elderly patients may require higher dosages than those recommended (see text).

<sup>b</sup>May be longer and more variable in the elderly; Short = <8 hrs.; Intermediate = 8-20 hrs; Long = 20-30 hrs; Very long >30 hrs.

*Source:* Based on Richelson, 1984.

Depression is a common, debilitating, and sometimes life threatening illness in the elderly. Dementia does not include as its normal course frequent tearfulness, agitation, fear or hallucination. Dementia is a cognitive disorder best managed by behavioral interventions. Dementia with complications such as depression and paranoid ideation cannot be treated with behavioral management alone but requires appropriate medical management as in other physical disorders such as diabetes and hypertension.

Right diagnosis  
Right drug  
Right amount

## **Dementia/Cognitive Disorders**

### **ATTITUDE / APPROACH**

- General attitude and approach
  - calm
  - flexible
  - non-resistive
  - guiding
- Non-verbal approaches
  - Know that your attitude/mood is contagious and felt by all, - practice smiling, looking open and friendly and listening
  - Assume an equal or lower position especially if the resident feels powerless
  - Move slowly
  - Avoid overwhelming the resident physically or verbally - approaching an anxious resident with three or more people may lead to a catastrophic reaction
  - Use lots of touch and allow time for the resident to touch you. Ask permission to touch.
  - Identify symbolic behaviors and their meaning - Assess cultural and ethnic background and incorporate this information into care plan.

### **VERBAL APPROACHES**

- Use concrete, exact, positive phrases and repetition of the same phrase to trigger an automatic response - anchor response to words, gestures, or colors, and ask resident to repeat command.
- Use one step commands which are simple
- Need to assess whether to offer the resident a choice. Give a suggestion or a command if unable to offer a choice. When possible, offer choices of where to eat, when to do grooming, bathing, etc. If the resident feels a lack of control he or she may become aggressive. At times, too many choices may be confusing so limit choices. For example, "Would you like cereal or toast?"
- Use calm, soft, slow voice pattern. Say one question at a time and wait for a response.
- Avoid arguing or reasoning

- Eliminate distractions
- Keep your promises, so make promises that you will be able to follow through with
- When the resident is present, include in conversation. Treat resident as an elder, not as a child. Validate resident's feelings. Use the resident's name frequently.
- Identify resident's vocabulary and use it.
- Give directions within attention span - if resident is too confused or combative always come back later
- Verbal and non-verbal messages should match
- Stand in front of person and make eye contact
- Assess whether the resident responds better to verbal or non-verbal messages. For example, a resident who might become combative when told verbally to use the walker may accept assistance if shown non-verbally how to use walker.
- Verbal excess disability - the resident is already impaired but how staff communicate with the resident may increase his/her disability - For example, the staff say "don't go outside," which may be confusing to a demented resident. It is far more effective and skillful to tell the resident exactly what you want them to do in slow, concise, and concrete sentences - like "Stay in the building." or "Walk with me." A nurse aide told a resident to "Hop in bed." and the resident tried to do it and said "I can't." The reason why confused residents pull the fire alarm is because "Pull" is clear and concise while "In case of an emergency" does not register.
- Residents with short term memory problems may confuse current requests with requests and occasions from their past. For example, mother never let me do that or I have told you children not to mess with that door, etc. With some residents, you can observe a transfer in personality traits. They will speak as if they were their parents, children, or teachers. You may improve communication with them if you find out who you are talking to and what the agenda is for that person.
- Make sure to speak in primary language. Seek help of translator if primary language is other than English or language in which you are not proficient. If a relative is the translator, schedule care planning around when relative may be present to explain care and procedures.
- Do not use words such as on, below, beside, between. These words are difficult for dementia patients to understand.
- If the person is having difficulty finding the right word, supply the word for him. This helps limit his or her frustration.

- When you do not know what the individual means, ask him or her to point to it, describe it, or to show you how it works.
- Use other signals besides words to convey what you mean - point, touch or demonstrate.
- Talk to the impaired individual and make a point of telling him or her what you are doing and why.

### **REALITY ORIENTATION**

- Of limited usefulness but assess to see if appropriate because of memory problems, it is not appropriate with all cognitively impaired individuals. It is helpful to orient residents to who you are, what task you will be helping them with, and what the next task will be. For example, "Helen, I'm your nurse and I'm here to help you get dressed." - The alternative reality of some confused individuals may serve as a coping mechanism and improve their quality of life. Therefore, in the severely demented, reality orientation may only increase their anxiety, exaggerate separation from what they love and trust, and increase their emotional pain by making them wrong in comparison to their perceived reality.

### **STRUCTURAL ADL SCHEDULES TASK SEGMENTATION**

- Mid-morning naps if fatigued
- Stick to toileting schedules
- Structured ADL schedules - Identify routines for rising, toileting to provide supervision adapted to individual needs.

### **DISTRACTION THERAPY**

- Distraction therapy
  - Use of mobiles
  - Use of family videos
  - Picture collages, scrapbooks

### **HEARING/ VISION EVALUATION**

## **Environmental**

### **CHECK BEDS**

- No siderails or only partial siderails unless indicated
- Low beds for easy access
- Padding or mattress on the floor beside the bed - Inflatable air mattress works well and can be easily cleared and stored.
  - Put beds in the low position.
- Non-rolling/working brakes or stabilizers
- Remove wheels from overbed tables

### **FURNITURE**

- Is furniture arranged poorly so resident may fall?
- Cover edges of furniture with foam to prevent bruising.



- Provide drawers with interesting, safe objects in them so the resident can go through these drawers as a substitute for going through drawers which belong to other residents or staff and which may contain items which are unsafe.

### **CHECK BATHROOMS**

- Are handrails and grab bars available, the appropriate height and secure in bathrooms?
- Raised toilet seats
- Bedside commode -place on rubber backed rug to prevent slipping
- Rubber backed area rugs in front of sinks and toilets
- If the resident is weak on one side, is the grab bar on his strong side?
- Is the toilet a high contrast color so it is easily visible, e.g.; toilet is white and floor is a darker color?

### **CHECK LIGHTING**

- Night lights available in all resident rooms and hallways.
- Is facility lighting appropriate for activities likely to be performed in area?
- Is lighting good on stairs and landings?  
- Use adequate non-glare lighting for daytime
- Do you have floor level lighting to reduce glare?
- Are light switches accessible/reachable from bed?

### **DO AN ENVIRONMENTAL ASSESSMENT FACILITY-WIDE**

#### **CHECK FLOORS**

- Are there areas where patterned carpeting may cause a resident to fall?
- Non-skid wax surfaces
- Rugs/mats with edges that do not curl
- Spills mopped up immediately
- Clutter-free and no extension cords
- No thresholds in doorways
- Pets out of resident area at night
- Non-reflective floors and surfaces - Do floors shine and glare is painful and impairs vision?

#### **CHECK STAIRS**

- Handrails with extra support at top and bottom of stairs on both sides
- Painted or marked top and bottom stair
- Risers painted in highly visible colors and not too high
- No skid treads
- Stairs well maintained

#### **ACCESSIBLE CALL LIGHTS**

- Call light attached to the resident's clothing. When resident moves, the call light goes off.
- Use cord of bright color so easily visible. Use reflective tape.

- Respond to call lights promptly
- Locate within resident's reach
- Orient resident regularly to use of the call light

### **CHECK CHAIRS**

- Wedge cushion for chair
- Bean bag seating to prevent sliding and to prevent resident from rising
- Saddle cushion
- Contour cushion
- Residents should be sitting in comfortable lounge chairs or winged chairs, not in wheelchairs all day
- Sturdy rocking chairs for anxious residents
- Recliner chairs
- Chairs of the appropriate height and size (P.T./O.T. consult)
- Wheelchairs in good repair

### **DECREASE NOISE**

- Noise can add to confusion for the confused resident as well as with hearing impaired residents.
- Use public address system as little as possible and have times of day with no P.A. system
- Use chimes instead of alarm for fire system.

### **VISUAL BARRIERS**

- Stop signs, yellow ribbons, curtains, distract wanderers by wall papering over exits, cover door knobs, bookcase to cover doorway, fabric over door handles, mirrors at exits to distract resident from leaving (Check with Fire Marshall).

### **USE ALARM SYSTEMS AND DOOR ALARMS, WANDERGUARD™ BANDS**

### **SECURED AREA OUTSIDE - INCLUDE THE OVER 90 NON-TOXIC PLANTS**

### **USE OF CUEING FOR RECOGNITION OF ROOM, APPETITE, AND TOILETING**

- Use symbols, signs, photos to direct resident to room. For example, one facility set up a contiguous loop for exercise with cueing such as showcases outside each residents' room which contains articles that are familiar to the resident so s/he knows his own room. For appetite cueing the course took residents by the kitchen so they would smell food cooking and had a refrigerator accessible to residents so they could get food when they wanted it, served meals family style with staff and residents eating together. Bathroom doors were left open on the walking course to cue residents to use the bathroom.

### **BARRIERS WHERE WANDERING RESIDENTS SHOULD NOT GO**

- Try to blend things into wall when you do not want the resident to focus on them; e.g.; exits. Door Guards: Vinyl Door Barrier for Wanderers.

### **THE PROS AND CONS OF SPECIALIZED UNIT**

- Is a secured area available for people who may wander from the facility?

## **DEVICES WHICH ASSIST WITH REACHING OR PLACING ITEMS WITHIN REACH**

### **USE A PRESSURE CHANGE ALARM BED CHECK SYSTEM OR POSITION CHANGE ALARM**

- Assess the use of an Ambularm™

## **CLUTTER-FREE ENVIRONMENT**

### **OUTDOOR ACCESS**

- Level and even walkways
- Curbs and steps clearly marked
- Rest areas /benches strategically placed in the shade

### **HALLWAYS**

- Chair/benches placed so residents can rest along the way in the long hallway
- Handrails available and firmly secured to the wall
- Avoid dead ends in walking areas or at least provide enough space so the resident can get turned around. Persons with Alzheimer's Disease. have difficulty turning due to brain changes and tend to go in a straight line, so provide a safe walking track for them to walk which is a safe, circular course.

### **INITIALLY ORIENT THE RESIDENT TO THE ROOM, FURNITURE, BATHROOM, AND REPEAT FREQUENTLY IF RESIDENT HAS MEMORY PROBLEMS.**

### **LOCATE THE RESIDENTS AT HIGH RISK FOR FALLING NEAR THE NURSES' STATION.**

### **ENLIST THE HELP OF ORIENTED RESIDENTS TO LET YOU KNOW WHEN A CONFUSED RESIDENT WANDERS INTO THEIR ROOM AND ENCOURAGE EMPATHY WHERE POSSIBLE FROM OTHER RESIDENTS.**

## **Family**

### **FAMILY FREQUENTLY DOES NOT UNDERSTAND LOVED ONES HEALTH PROBLEMS OR THE CHANGE IN PERSONALITY.**

- Nursing can be most helpful in educating family about the diseases and how family can play a positive role in their senior's life. Family also needs to know that LTC facilities operate under different regulations than hospitals. It is helpful if social services can explain the Medicare/Medicaid Insurance maze to them. Families, like their loved ones, need to keep a sense of control. Allow them choices, decision making opportunities. This is a very chaotic, upsetting time for most families. There are times when dysfunctional families can intentionally or unintentionally harm the resident. In these cases, after appropriate intervention by nursing, social services and the primary care provider, Adult Protective Services may be involved. The safety and well being of the patient is the primary responsibility of the health care team, especially if the patient is unable to protect himself/herself.

# BEHAVIOR PROBLEMS

**FIRST COMPLETE BASIC ASSESSMENT TO RULE OUT MEDICAL ILLNESS BEFORE PROCEEDING WITH THIS SECTION.**

## Medications

### DOSAGE - MULTIPLE DOSAGES/MULTIPLE MEDICATIONS

- Seniors usually require 1/2 - 2/3 of the normal dose especially there is a hepatic/renal disease, low body weight, and malnutrition.

### CHECK DRUG SUBSTITUTIONS, INTERACTION, SIDE EFFECTS - psychotropics, diuretics, cardiovascular

- Be aware that for institutionalized individuals the greater risk of falls is in the first six weeks, however, the risk remains somewhat higher for the first six months.
- Evaluate medications for drug toxicity
- Some residents may be toxic at therapeutic levels, while other residents may be at therapeutic levels when medication is below usual accepted range.
- Psychotropics
  - Recommend to physician avoidance of long-acting barbiturates and benzodiazepines and limit other sedatives/tranquilizers if indicated, for example PRN.
  - Have residents void before receiving tranquilizers/sedatives
  - Do not hold back medication if physician feels it is indicated. Depression and psychosis are as real as physically observed disabilities.
- Diuretics
  - Offer frequent toileting assistance if diuretics are used
  - Minimize use of diuretics at bedtime
  - May cause hypotension
  - Will require electrolytes, BUN, and creatinine at least every 6 months to monitor renal status
- Cardiovascular
  - Monitor residents for orthostatic dizziness
  - Watch for signs of weakness or fatigue - taking anti-hypertensives?
  - Many cardiac medications affect Heart Rate.
  - Teach resident to rise slowly from a sitting or lying position

### HAVE ANY MEDICATIONS BEEN ADDED TO REGIMEN WHICH MAY INCREASE FALLS?

- Benzodiazepine, psychotropics, anti-convulsants/mood stabilizers, cardiovascular meds

### DIGITALIS LEVELS

- Heart rate that is dramatically fast or slow decreases the efficiency of the heart resulting in hypoxia to vital organs including the brain.

**DILANTIN™ LEVEL VPA(VALPROIC ACID) TEGRETOL™**

- May cause sedation and dizziness even at therapeutic levels. Disorientation may be experienced as well as nausea. These medications require CBC and liver function tests every 6 months.

**SMA 6 (BLOOD CHEMISTRY PANEL)**

- Elevated BUN with creatinine may indicate renal failure or dehydration. Electrolytes (Na, K, Cl) are important in muscle contractibility - includes the cardiac muscle

**VOID BEFORE GIVING TRANQUILIZERS / SEDATIVES**

**FREQUENT TOILETING ASSIST IF ON DIURETICS**

**LIMIT LONG-ACTING BENZODIAZEPINES**

- When possible, Ativan™ is a popular short-acting benzodiazepine.

**ADMINISTER PAIN MEDICATIONS BEFORE ROM AND TRANSFER**

- Non-Steroidal Anti-Inflammatory drugs are useful, but these drugs continue to have a higher incidence of gastrointestinal, hepatic and renal side effects. An acetaminophen may be a better choice for osteoarthritis. Use adequate pain meds to include narcotics in proper dose. Addiction is not an issue in this population. Be watchful for sedation and CONSTIPATION.

**CARDIOVASCULAR INSUFFICIENCY - Syncope, Orthostatic, TIA, Arrhythmia, Hypertension**

**AUSCULTATE SITTING AND WALKING**

- A resident may have a normal sinus rhythm when sitting yet go into an arrhythmia with movement resulting in hypoxia

**TEACH TO CHANGE POSITION SLOWLY**

**USE OF ELASTIC STOCKINGS**

- Use when lack of potency of lower extremity circulatory system exists. Are their pedal pulse, sensory intact?

**EKG**

- Gives a cardiac reading at time of test

**24 HOUR HALTER - MONITOR**

- Can show cardiac reaction to 24<sup>o</sup> of activity and stimulus

**O<sub>2</sub> SATURATION**

- Important to check with any change in mental or physical condition. Increased frequency of respiration can cause a misleading reading as can anemia.

### **CXR (Chest X-Ray)**

- May be indicated in change of mental or physical condition. Pneumonia is very common in LTC population. If CHF is noted on X-ray, it is probably advanced. There may be no rales, rhonchi accompanying an infiltrate.

### **SMA6 (Blood Chemistry Panel)**

- Measures renal status and may indicate dehydration. Electrolytes (Na, K, Cl) are necessary for muscle contractibility, including the heart muscle.

### **ORTHOSTATIC BP**

- May check by doing blood pressure and heart rate while lying, sitting and standing. This must be done in this order and with a 1 minute wait period between each reading.
- Gradually increase mobility after confinement to bed or chair to prevent falls due to orthostatic hypertension

### **HEART RATE**

- Heart rate that is dramatically fast or slow decreases the efficiency of the heart resulting in hypoxia to vital organs including the brain.

### **CHECK PACEMAKER**

- Yearly evaluation

## **Infection**

### **UPPER RESPIRATORY INFECTION**

- Seniors have fewer colds, sinusitis and otitis media than the young, yet they do occur. Suggest that facility have at least one ophthalmoscope with staff trained to assess using this tool.

### **FEVER - FREQUENTLY AFEBRILE**

- Least reliable of vital signs when assessing the elderly. They can be septic while afebrile.
- Lung Sounds
  - Many elderly have decreased breath sounds due to lung disease, smoking, etc. This may be their baseline. It is wise to compare what you are hearing with what has been heard in the past. A senior may have no rales - cough or wheezing and still have pneumonia.
- CBC
  - These are important in assessing the immune system and in checking for anemia.
- CXR (Chest X-Ray)
  - May show infiltrates, CHF and other pulmonary disease. Portable x-ray is not as reliable as large x-ray, particularly when x-raying areas of greater density

- UA - C&S (URINE ANALYSIS - CULTURE AND SENSITIVITY)  
- FIRST TEST TO DO WHEN THERE IS A CHANGE OF MENTAL PHYSICAL CONDITION OF UNKNOWN ETIOLOGY. ELDERLY MAY HAVE NO PHYSICAL SYMPTOMS. BACTERIA IN URINE WITHOUT WBCs ARE NOT USUALLY SIGNIFICANT - RESULT OF CONTAMINATION.
- O<sub>2</sub> Saturation  
- As previously, may be false positive if resident is hyperventilating or anemic. This is a very useful tool in assessing cardiac/pulmonary status.

### **URINARY TRACT INFECTION**

- Most common cause of physical or mental change. Usually caused by urinary retention, catheters, poor hygiene.

## **Hyperglycemia / Hypoglycemia**

### **CHECK BLOOD SUGAR**

- Hypoglycemia can cause deterioration in motor/neural/cognition - may become lethargic and confused because brain is receiving inadequate glucose

## **Dehydration**

### **NEEDS 1.5 TO 2 QUARTS OF WATER PER DAY unless otherwise restricted**

- Common problem in LTC. Thirst mechanisms may be impaired by disease. Resident may have impaired motor abilities and be unable to reach water in his environment. High use of diuretics, while necessary, contribute to dehydration, as does swallowing dysfunction

## **Constipation**

### **CHECK BOWEL SOUNDS**

- Listen for at least 2 minutes in each quadrant before deciding there are no bowel sounds.

### **CHANGE IN MENTAL STATUS**

- May be caused by meds or illness - UTI and pneumonia most common medical problem.

### **ABDOMINAL DISTENTION - Coffee Ground Emesis**

- Distention may indicate an obstruction, renal, hepatic or biliary disease. Coffee ground emesis indicates a GI bleed.

### **IMPACTION**

- If low, may be removed manually with care. Higher up impactions are only identified by x-ray, scan and require laxatives and fluids.

# Pain

## INITIAL PAIN ASSESSMENT

- Pain is whatever the experiencing person says it is. The individual's perception of pain is a unique experience that includes the variables of the patient's culture, gender, past pain experience, meaning attached to pain, and physiologic alterations, including those due to aging.
- Studies have found nurses and doctors do not ask patients "Are you in pain?" Even very demented residents may respond to simple straight forward questions. This should be a routine question in any assessment. Cognitively disabled may not be able to express pain in accepted ways. Agitation, yelling may be the only clue.
  - The fear of addiction remains common among patients, family members, physicians, and nurses despite large studies indicating the risk is less than 1%. Concerns should be sedation interfering with activities of daily living (most people develop tolerance) and constipation.
- Intractable pain
  - Assess the patient's pain and believe his assessment of the pain. Pain is a subjective experience rather than an objective experience.
  - Give analgesics (pain medication) in doses high enough and frequent enough to control the pain.
  - Treat the pain before it returns. This involves maintaining constant blood levels of the analgesic at all times and is achieved by giving the medication around the clock rather than "PRN". (Cushing, 1992)
- Demographics and General Information on Pain in Nursing Home Residents: (Fried, 1993)
  - Pain is frequently associated with depression. Depression is most common in residents who have physical disorders which cause pain. Chronic pain is sometimes relieved by addition of low dose anti-depressants in conjunction with analgesic.
  - Only 40 to 45% of residents who reported pain in studies have it noted on their charts.
  - For resident who are severely demented, there is even less documentation of or treatment for pain. Care providers are forced to rely on pain behaviors such as fidgeting, facial grimacing and irritability. However, the accuracy of pain rating based on these observations is unknown.

## Behaviors Associated with Pain:

Type of Behavior	Examples
Facial expression	Grimacing, clenching teeth, tightly shutting lips, gazing/staring, wrinkling forehead, tearing
Vocalization	Moaning, groaning, grunting, sighing, gasping, crying, screaming
Verbalization	Praying, counting, swearing or cursing, repeating nonsensical phrases
Body action	Thrashing, pounding, biting, rocking, rubbing
Behaviors	Massaging, immobilizing, guarding, bracing, eating/drinking, applying pressure/heat/cold, assuming special position/posture, reading, watching television, listening to music

From Puntillo, K., & Wilkie, D. (1991). Assessment of pain in the critically ill. In K. Puntillo (Ed.), *Pain in the critically ill: Assessment and management*. Gaithersburg, MD: Aspen. Reprinted by permission.



## Sleep

### ASSESSMENT OF SLEEP

- Nature of sleep problem including characteristics, clinical course, its duration, the circumstances under which it developed, any precipitating or accentuating factors, any previous treatment and results, and the impact of the sleep problem on resident's life.
- Usual sleep-wake pattern for 24 hours - as we age, our sleep pattern changes. Seniors typically do not sleep as long, wake sooner and more frequently, than when they were younger. Assure them this may be normal.
- Bedtime rituals/routines and environmental factors - noise, temperature
- Diet and drug use (both prescription and over the counter) - including usual intake of caffeine (coffee or cola) or alcohol. Excessive use of alcohol leads to difficulty in staying asleep. Withdrawal of relatively low doses of short or intermediate-acting benzodiazepines produce rebound insomnia and abrupt withdrawal of long acting benzodiazepine hypnotics may cause both insomnia and nightmares. Insomnia is aggravated by stimulant drugs, steroids, energizing anti-depressants or beta-adrenergic blockers. These drugs cause sleep problems if taken at bedtime.
- Illness factors - Changes in health, including Alzheimer's disease, cardiovascular disease, pulmonary disease, arthritis, pain, prostatic disease, endocrinopathies, and other illnesses.
- Objective Data - Family and significant others may provide insight into usual patterns and certain aspects of sleep. Resident may have a diagnosis of being a "night" person who sleeps during the day.
- Subjective - Many short sleepers who do not complain of insomnia actually sleep much less than most insomniacs, but while short sleepers feel rested and alert on awakening in the morning, most insomniacs feel tired and sluggish. The patient's complaint of insomnia, rather than the actual amount of sleep, is the criterion for diagnosis. Health care providers should not be biased by own sleep habits.
  - Listen to verbal comments of not sleeping well, of not feeling rested, of being tired, of being awakened earlier than usual, or of having interrupted sleep or being more irritable, restless, lethargic, a greater sensitivity to pain, an increase in accidents and falls.
- Changes in emotional life - stressors such as retirement, hospitalization or the death of a loved one.
- Chronic insomniacs generally show high levels of psychopathology and a tendency to internalize emotional conflicts, which leads to psychophysiologic activation and a state of hyperarousal. Acute insomnia is also common in many psychiatric conditions, including depression, anxiety disorder, mania, acute schizophrenia and organic brain syndrome or other psychiatric illness. The insomniac patient may use his symptoms for considerable secondary gain. It is not unusual for insomniacs to avoid family and social interactions by insisting they are too tired or by protesting that a certain activity will adversely affect their sleep. May be used to avoid sexual relations.

- Treatment depends on type of sleep difficulty and its etiology. If the difficulty is in falling asleep, the focus should be on pre-sleep routine and his mental activity while attempting to fall asleep. If the complain is difficulty staying asleep, the possibility of medical problems or unsatisfactory environmental conditions should be investigated. Early final awakenings are often symptomatic of endogenous depression and warrant inquiry about other depressive symptoms.
- Assessment of pain - If pain predominates, analgesic agents should be used to their maximum therapeutic benefit.
- Fear of death: Patients who are seriously ill have a greater fear of death at bedtime, and frequently have severe difficulty getting to sleep. Patients with asthma, COPD or CHF often experience disrupted sleep because they fear the recurrence of symptoms during sleep.

#### **TREATMENT OF COMMON DISORDERS:**

- Adjustment Sleep Disorder:
  - It arises in fair to good sleepers who are coping with recent stressors such as retirement, hospitalization, or death of a loved one. Usually will resolve with time as person adapts to stress-related event.
  - Problems with onset or maintenance of sleep result in daytime irritability, anxiety, lethargy, slowed cognition, and tearfulness. Often, worry and concern about sleeplessness create a level of arousal that is incompatible with sleep.
  - Treatment is more often needed in individuals with few sources of emotional support. Behavioral treatment is preferred. Treatment seeks to restore normal sleep. Relaxation tapes, proper sleep hygiene, self-help books such as No More Sleepless Nights.
  - Hypnotics are indicated if the patient is overwhelmed by the situation. However, they should only be administered for a few days or weeks.
  - Psychophysiologic Insomnia: Usually develops after an adjustment disorder has developed and is combined with poor sleep hygiene. Older adults with psychophysiologically insomnia associate their bed and bedtime rituals with frustration and increased mental and physical arousal. The sleep disturbance continues as a result of conditioned, learned arousal, even after normal coping and sleep habits are re-established. Two behavioral therapies are effective:
    - a. Stimulus Control Therapy: Used when sleep onset is the problem. If the patient does not go to sleep in 10 minutes or less, he is instructed to get up and then return to bed only when feeling sleepy again, repeating this pattern until sleep onset occurs quickly. This establishes a new habit of good sleep.
    - b. Sleep Restriction Therapy: Recommended when sleep maintenance is presenting problem. Average number of hours of sleep is determined. Then the patient is allowed to spend only this amount of time in bed. As sleep improves, the patient is allowed to retire 15 minutes earlier. This method consolidated the amount of sleep, leading to deeper sleep, faster onset, and fewer awakenings.

- **nadequate Sleep Hygiene:** Irregular or poor sleep habits and sleep-incompatible behaviors constitute inadequate sleep hygiene.
  - Maintain a regular sleep schedule with a regular arising time. Irregular habits around the time they go to bed and rise can lead to sleep problems. Patients with poor sleep hygiene often spend excessive time in bed trying to sleep or follow highly irregular schedules for going to sleep and arising. Such practices deprive them of strong behavioral cues for deep, refreshing sleep.
  - Factors that heighten arousal include caffeine, cigarettes, alcohol withdrawal, working until bedtime, and clock watching may forestall sleep. They are preoccupied with their inability to sleep.
  - Hypnotics are best avoided because patients have increased risk of tolerance and continued sleep disruption from sleep-disruptive behaviors.
  - Make certain bedroom is quiet, comfortable, cool and secure. Decrease noise, the appropriate strategy would be to reduce the frequency of interruptions to sleep. Avoid caffeine after 12 o'clock noon.
  - Avoid napping during the day.
  - Get regular and gentle exercise around midday. Patients with insomnia often report low or inconsistent levels of physical activity during the day. Increase exercise, however, limit physical exercise or stimulating mental activity close to bedtime. This may also contribute to difficulty falling asleep.
  - Bed partner can often give useful information in assessing difficulties related to disordered schedules and routines. Especially myoclonus nocturnus (jerking movement of legs) and "restless legs syndrome".
  - Abstain from stimulating drugs (caffeine or decongestants) in the evening. Many over the counter sleep remedies contain anti-histamines which will actually worsen the sleep condition over time.
  - Avoid heavy meals or hunger at bedtime.
  - Get out of bed if awake. Limit time in bed to intimacy or sleep. Do not watch TV and read in bed. Restrict total time I bed to 6.5 to 7.5 hours. per day.
  - Avoid worry or frustration in bed. Schedule time to wind down and relax before going to bed.
  - Habitual pre-sleep activity that is comforting to the individual and enhances sleep. Pre-sleep activity for men tended to include food, drink, television, and walking. Pre-sleep activity for women tends to include hygienic activities, prayer, reading, and listening to music and watching TV. Sleep was more satisfying for those who followed a routine.
- **Mood Disorders:**
  - Alteration in sleep is the hallmark symptom of such psychiatric disorders as major depression, mania, dysthymic disorder, and cyclothymic disorder. Major depression, in

particular, may disrupt an elderly person's ability to fall asleep, stay asleep, or both. Manics may not sleep for days at a time.

- Often difficult, but important, to determine which came first insomnia or depression.

- Treatment is warranted when depression is suspected.

- Before antidepressants are prescribed, all depressed elderly should be screened for other causes of insomnia, particularly restless leg syndrome and myoclonus because antidepressants may worsen these syndromes, further disrupting the patients' sleep and mood.

- Medical Illness and Treatment: One study found that 12 of 26 standing orders in a hospital included doses of hypnotic that are twice the recommended dosage for the elderly and often provide inappropriate repeat doses.

- Physician's efforts to medicate underlying disease processes may result in sleep disruption. The most significant offenders are steroids, thyroxine, theophylline, and many centrally active antihypertensives.

- Insomnia secondary to symptoms of medical illness is best managed by treating the underlying medical disorder. If pain predominates, narcotics and NSAIDs for bone pain or inflammatory conditions should be administered to their maximum therapeutic benefit.

- Dementia/Delirium:

- Sleep disturbances in patients with dementing illness range from increased awakenings and nocturnal wanderings to agitation and confusion. "Sundowning" frequently leads to placement in an institution.

- The changes in sleep in patients with dementia arise from degeneration of cortical and brain stem structures, resulting in poor accommodation to the transitions from sleep to wake and lighter, more broken sleep.

- Treatment: Management of underlying metabolic, neurologic, or infectious processes. Behavioral management includes proper sleep hygiene, particularly exposure to morning light. Safety at night includes a night light and putting the mattress on the floor and removing glass objects.

- When dementia is accompanied by agitation, low-dose antipsychotic medications may work. However, antipsychotics carry the risk of bradykinesia, rigidity, and tardive dyskinesias. Short acting Benzodiazepine or antidepressants such as trazodone should be tried and titrated to optimal dose; if not affective, then a trial of low dose antipsychotics may be tried.

- Sundowning

- Occurs in patients with organic brain dysfunction. The classic symptoms are daytime drowsiness combined with nighttime confusion, agitation, and anxiety. At night residents tend to wander, exhibit speech and behavior that are not of character. Patients have a strong need to maintain contact with a familiar environment. They feel that their fading

cognitive abilities are enhanced during the daytime. At night, however, they feel less safe and confident, and staying awake makes them feel more secure. Underlying environmental or organic factors that could cause sundown syndrome should first be ruled out. Such causes are easily treated. Simple environmental orientation procedures may help - keeping a light on in the bathroom. Medications include Haldol or Trazodone to reduce agitation, anxiety, and wandering and allow them to sleep. Hypnotics are contraindicated because they may cause patients to become more disoriented and confused. Paradoxically, these medications will excite already disinhibited patients. The patient's drug regimen should be evaluated for its potential to produce some or all of the symptoms of sundown syndrome. Medications that have an anticholinergic component, such as antidepressants, antihistamines, antiparkinsonism drugs, and antispasmodics, are particularly likely to have this effect. Non-essential drugs should be reduced or stopped.

- Prescribing Guidelines for Hypnotic:

- Should be the intervention of last resort, use the lowest effective dose. Use half of the adult dose in patients over age 65.

- Monitor for side effects. Check interaction of hypnotic with alcohol or drugs, and other interactions with lung or heart disease, Central Nervous System disease. Check for interaction with other medications such as Tagamet™, phenobarbital and Dilantin™.

- Dispense a limited number of doses (#20) and follow for cognitive or behavioral changes.

- If the medication is needed for more than two weeks, consider a maximum of three doses per week to lessen the chance of tolerance.

- Selection of an appropriate hypnotic depends on the target symptoms, whether related to sleep onset, sleep maintenance, daytime anxiety, or possible depression.

- Consider adverse effects on the patient with lung or heart disease, Central Nervous System disease, or a history of alcohol abuse.

## **Delusions, Hallucinations, Depression**

### **ASSESS AGGRESSIVE BEHAVIOR**

- Identify the pattern of behavior, e.g., time , triggers.
- Assess resident response to verbal/non-verbal messages. Use non-threatening positives.
- Offer choices of when to eat, when to do grooming, bathing when possible.
- Identify early signs of aggression or increased agitation and intervene at that point, by distracting or removing them from the situation to prevent escalation.
- Reduce or eliminate noise.
- Learn sources of comfort or discomfort and communicate to all staff.
- Do not argue with resident. If resident refuses treatment, return at another time. Never try to talk a psychotic resident out of his hallucination.

## **ASSESS PSYCHOACTIVE MEDICATIONS (this does not include anti-depressants)**

- According to OBRA, may be used if the behavior:
  - Is dangerous to resident or other
  - Interferes with staff's ability to deliver care
  - Impairs function of resident
- Steps to Use
  - Chart behavior problems
  - Obtain a physician's order
  - Begin with lowest dose
  - Observe for side effects
  - Chart behaviors for 48 hours
  - Re-evaluate at later date. The effects of an antipsychotic which has been lowered or stopped may not be seen for many weeks.
  - Withdraw - "not to be a permanent order" except when patient has diagnosis supporting chronic therapy such as schizophrenia, Bipolar, chronic depression. A slow, careful, tapering off may be tried to evaluate patient's current need.

## **CONTRACTING**

- Depending on the mental status of the resident, make clear the relationship between behavior and consequences.
- Give rewards when behavior is appropriate.
- Eliminate behavior modification. Not useful with dementia.
- Actively listening to the resident will give important clues to behavior. For example, one resident who was fine during the day stayed up all night. When staff listened to her she conveyed that she was afraid to become old and senile or go to sleep because she was afraid she would lose her mind or die. In care planning, when she was involved, she said she wanted a digital clock so she could see what time it was during the night. Also, her family decided to come and help her get ready for bed. The clock and the family assistance helped her sleep at night. Now she gets up less frequently, but she still gets up. However, no one minds because they understand why she is up.
- Use interview techniques with open ended question centering on five senses and feelings. Remember, the nursing home population is not usually educated in communication skills. It is helpful to find out why they exhibit a given behavior. For example, are they angry about nursing home placement, do they have a history of combative behavior, are there other family problems, or a dysfunctional family system. It is very unlikely that you will see great changes in behavior because they are comfortable with their behavior even if it is not in their best interest. A dysfunctional young person often becomes a dysfunctional senior.
- Reality orientation - of limited usefulness but assess to see if appropriate. Because of memory problems, it is not appropriate with all cognitively impaired individuals. It is helpful to orient residents to who you are, what task you will be helping them with, and what the next task will be. For example, "Helen, I'm your nurse, and I'm here to help you get dressed." The alternative reality of some confused individuals may serve as a coping mechanism and improve their quality of life. Therefore, in the severely demented, reality orientation may only increase their anxiety, exaggerate separation from what they love and

- trust, and increase their emotional pain by making them wrong in comparison to their perceived reality. Reality orientation with psychotic patients must be done skillfully. Never try to argue them out of their reality.

## **Dementia/Alzheimer's Disease**

### **ATTITUDE/APPROACH**

- General attitude and approach
  - Remain calm. Do not overreact to behavior.
  - Stay flexible and non-resistive.
  - Guiding (not controlling)
  - Be patient and stay neutral.

### **VERBAL APPROACHES**

- Use concrete, exact, positive phrases and repetition of the same phrase to trigger an automatic response - anchor response to words, gestures, or colors, and ask resident to repeat command.
- Use one step commands which are simple.
- Need to assess whether to offer the resident a choice. Give a suggestion or a command if unable to offer a choice. When possible, offer choices of where to eat, when to do grooming, bathing, etc. If the resident feels a lack of control, he or she may become aggressive. At times, too many choices may be confusing, so limit choices. For example, "Would you like cereal or toast?"
- Use calm, soft, slow voice pattern. Say one question at a time and wait for a response.
- Avoid arguing or reasoning.
- Eliminate distractions.
- Keep your promises, so only make promises that you will be able to follow through.
- When the resident is present, include them in the conversation. Use the resident's name frequently.
- Identify resident's vocabulary and use it. Use language and expressions that are within the life experience of the resident. A very old, demented person is unlikely to understand explanations of HMO's, current new medical practices, or slang expressions. A demented person does not acquire new information well. Rely on their experiences as a younger adult.
- Treat resident as an elder, not as a child. Validate resident's feelings.
- Give directions within attention span. If resident is too confused or combative, always come back later.

- Verbal and non-verbal messages should match. Stand in front of person and make eye contact.
- Assess whether the resident responds better to verbal or non-verbal messages. For example, a resident who might become combative when told verbally to use the walker may accept assistance if shown non-verbally how to use walker.
- The resident is already impaired, but how staff communicate with the resident may increase his/her disability. For example, the staff say “don’t go outside,” which may be confusing to a demented resident. It is far more effective and skillful to tell the resident exactly what you want them to do in slow, concise, and concrete sentences, such as: “Stay in the building” or “Walk with me.” A nurse aide told a resident to “Hop in bed” and the resident tried to do it, and said, “I can’t.” The reason why confused residents pull the fire alarm is because “Pull” is clear and concise, while “In case of emergency” does not register.
- Residents with short term memory problems may confuse current requests with requests and occasions from their past. For example, “Mother never let me do that,” or “I have told you children not to mess with that door,” etc. With some residents, you can observe a transfer in personality traits. They will speak as if they were their parents, children, or teachers. You may improve communication with them if you find out who you are talking to and what the agenda is for that person.
- Make sure to speak in primary language. Seek help of translator if primary language is other than English or a language in which you are not proficient. If a relative is the translator, schedule care planing around when relative may be present to explain care and procedures.
- Do not use words such as “on,” “below,” “beside,” or “between.” These words are difficult for dementia patients to understand.
- If the person is having difficulty finding the right word, supply the word for him. This helps limit his or her frustration.
- When you do not know what the individual means, ask him or her to point to it, describe it, or to show you how it works.
- Use other signals besides words to convey what you mean - point, touch, or demonstrate.
- Talk to the impaired individual and make a point of telling him or her what you are doing and why.
- Break down complex tasks into single steps. Show the resident how to begin.
- Make sure the person’s clothing and articles of toileting do not require motor skills the resident no longer has.



- Provide opportunities for the resident to succeed in activities that she can still do.
- Signs of Increasing Anxiety:
  - Head: loss of eye contact
  - Arms and hands: repetitive movements, wringing hands, clenched fists.
  - Legs and body: repetitive movements, increase in motor activity, such as frequent changes in position or pacing.
  - Voice and speech: change in tone of voice, repetitive sounds, crying, complaining.
  - When these signs observed, delay care or take steps to comfort, reassure or distract the resident.
  - Re-assess the correctness of approach.
- Behavior Management Plan
  - Four Steps for Dealing with Problem Behaviors:
    1. Immediate action to control a threatening or dangerous behavior problem.
    2. Medical evaluation to look for medical or other causes of the problem that need treatment.
    3. Behavior assessment to observe and describe the behavior.
    4. Care plan development to describe realistic goals for behavior change.
  - Immediate Action Techniques:
    - Stay calm and use a firm tone of voice.
    - If it is necessary to protect yourself, use a pillow or padding in the chest and shoulder area.
    - Do not use gestures that startle or frighten the resident.
    - Stay at a safe distance from the resident.
    - Do not confront or accuse the resident of wrongdoing.
    - Do not argue or try to reason with the resident.
    - Whenever possible, move the resident away from the triggering event.
    - If restraint is needed, keep the resident safe and use the least amount possible for the shortest period of time.
    - Offer reassurance through gentle touching and express support when the resident is able to hear you. Be selective about use of touch, especially with angry, depressed and/or paranoid schizophrenic residents. Some residents will find touch comforting; others will feel threatened.

### **NON-VERBAL APPROACHES**

- Know that your attitude/mood is contagious and felt by all - practice smiling, looking open and friendly and listening. Show a positive attitude
- Assume an equal or lower position, especially if the resident feels powerless.
- Move and speak slowly. Be respectful.
- Avoid overwhelming the resident physically or verbally - approaching an anxious resident with three or more people may lead to a catastrophic reaction. Do not call out or surprise resident from the rear where they cannot see.

- Make sure that your actions match your verbal message. Exaggerate your expressions if they are helpful in getting a message across.
- Learn likes and dislikes, family situation, communication style, past behavior problems, preferred routines and habits. Learn sources of comfort or discomfort.
- Learn three things that give the resident comfort.
- Do not force the resident to do anything when she will not cooperate.
- Anticipate the resident's needs during care.

### **MUSIC THERAPY**

- Music can assist with de-escalating a resident
  - For example, one resident loved classical music. The staff discovered that if they turned her radio to a classical music station just as she begins to escalate, she will relax and take a nap instead of trying to leave the building.

### **DISTRACTION THERAPY**

- Limit distractions in the room while giving care.
- Use distraction to keep the resident interested in something else during an activity that causes behavior problems.
- Distraction Therapy
  - Use of mobiles
  - Use of family videos
  - Picture collages, scrapbooks
  - Use of mirror

### **RECREATION**

- Recreation Therapy
  - Residents who are involved in activities will usually not try to get up, so this should be a restraint-free time each day.
  - Restructure activities so residents who are not confused or only slightly confused are in one group and cognitively impaired are in small group activities or one-to-one activities.
  - Use volunteers for one-to-one activities.
  - Select specific sensory experiences geared for their enjoyment. For example, an angora sock massage or blow dryer massage.

### **EXERCISE**

- Exercise - There should be a planned daily exercise program. Schedule periods of physical activity.
- Provide time for rest throughout the day.
- Therapeutic touch: Some people like to be touched, and others do not. Need to assess this before you touch the resident. Individuals who have been touched adequately are more emotionally satisfied and less stressed. It is interesting to contemplate that if the frail

- elderly return to infantile needs, does their need for touch increase. An infant cries to be touched. Do the frail elderly cry to be touched and cared for in the same way? It could be that their only form of communication is through touch. Do they reach out for us begging for human contact and a gentle touch? Touching makes us equal. The resident can be helped to feel her caregivers understand her needs more completely if touch is the bridge to understanding. Touch is a learned behavior. The nursing home population may not have experienced positive tactile experience in past relationships. A thorough social history is beneficial in ascertaining the family's history of touching. Avoid touching paranoid schizophrenic residents or angry, depressed residents without permission.
- Opportunities for Touch:
  - Contact with other people.
  - Contact with animals, gardening, finger foods, and objects.
  - Use lots of touch and allow time for the resident to touch you.
  - Ask permission to touch.
  - Identify symbolic behaviors and their meaning. Assess cultural and ethnic background and incorporate this information into the care plan.

### **ASSESSMENT OF HEARING AND VISION**

- Residents with impaired hearing and/or vision may appear to have mental status problems when this is not the case.
  - Hearing - Has hearing been checked recently? Does the resident need a hearing aid? If the resident has a hearing aid, does it function properly? Does the resident have a problem with excessive ear wax?
  - Vision - Does the resident have cataracts? Have glasses been checked in the past year? Are glasses in good repair? Are they cleaned daily?
  - Be aware of hearing, seeing, and speech problems and aids the resident should be using.

### **REMINISCENCE**

- Reminiscence therapy - This enables residents to talk about life experiences and provides you with important information about hobbies and interests and potential activities for the resident . For example, in reminiscence therapy activities, staff found out one resident was an ex-prize fighter. Therefore, facility staff arranged for a volunteer to take him to a gym three times a week so he could work out. This has substantially decreased his agitation. Also, ask residents about important anniversary dates. Mortality rates are very high for important anniversary dates. For example, one resident was very anxious and agitated one day. A staff member asked her about it, and she said her child had died on that date ten years before.

### **BEHAVIOR MANAGEMENT AND BATHING - INTERVENTION**

- Environmental:
  - Ensure warm water and comfortable bathroom temperature.
  - Post privacy signs on bathroom doors.
  - Decorate to resemble residential bathroom (colored paint and towels).
  - Install gentle-spray shower heads.
- Behavioral:
  - Individualize care to the patient/resident:
    - a. Find out about and accommodate prior preferences for type of bathing and time.
    - b. Use familiar objects (favorite bathrobe, powder, or bath oil).

- Decrease potential for distress related to care techniques:
  - a. Allow flexibility in scheduling when possible.
  - b. Allow choice of tub, shower, or sponge bath.
  - c. Provide for privacy; have resident disrobe in bathroom to avoid “public” appearance in unclothed state. Avoid rapid transportation to the bathroom without cueing.
  - d. Explain the care process; use task segmentation to increase comprehension.
  - e. Keep patient warmly covered .
  - f. Use reassuring statements or touches as appropriate.
  - g. Allow patient to self-perform care in an unrushed fashion.
  - h. Give positive feedback and personal regard during and after interaction. Defer or cancel bathing if patient is unable to cope.

### **ANTI PSYCHOTIC DRUG USE**

- According to OBRA, may be used when:
  - Resident is dangerous to self or others
  - Resident interferes with staff’s ability to deliver care for resident
  - Resident is not able to function
- Steps to Use
  - Chart behavior problems
  - Obtain a physician’s order
  - Begin with lowest dose
  - Observe for side effects
  - Chart behaviors for 48 hours
  - Re-evaluate
  - Withdraw - “not to be a permanent order”
- Antipsychotic drugs may be permanent if resident has a supporting disease of schizophrenia, bipolar, schizo affective or depression. Sometimes a slow, careful taper may be tried to assess for a highest functioning with lowest dose. Remember, it may take many weeks for the effects of lowering antipsychotic drugs to become apparent.

## **Environmental Therapy**

### **AVOID SENSORY OVERLOAD**

- Avoid sensory overload - Decrease or eliminate noise and high activity level. It can be very confusing to the frail elderly, as with residents with brain trauma or psychosis.
- Decrease noise - Noise can add to confusion for the confused resident as well as with hearing impaired residents.
  - Use public address system as little as possible and have times of day with no P.A.
  - Use chimes instead of alarm for fire system.
- Reduce Distractions
  - Reduce intercoms, TV’s, buzzers, and background noise.
  - Put residents who are confused by large groups in small groups.
  - Remove mirrors, confusing signs, wall coverings or slipcovers with busy patterns.
  - Put residents who are sensitive to noise in rooms with quiet locations.

## **PERSONALIZE ROOM**

- Strongly encourage the use of personal possessions in rooms. This provides a great deal of security and comfort to residents, particularly confused residents.
- Personalize Living Areas
  - Personal items and remembrances in resident's room.
  - Encourage expression of different cultures and ethnic backgrounds.

## **NIGHT TIME ACTIVITIES**

- Have night time programs for those residents who cannot sleep at night. The elderly generally need less sleep.

## **STAFFING**

- Consider allowing staff to wear ordinary clothing rather than nursing uniforms. Deinstitutionalize your facility and get away from the medical model of care to create a more homelike environment. This helps to reduce stress for residents. Consistent staff schedule. Permanent staff assignments will increase rapport.
- Reduce turnover in staff.
- Allow resident to choose caregivers. Use non-nursing personnel as much as possible.
- Use a picture taken before the dementia developed to help staff think of the resident as a person, not a problem.
- Accessible Call Lights
  - Can be attached to the resident's clothing. When resident moves, the call light goes off.
  - Use cord of bright color to make it easily visible.
- Respond to call lights promptly.
  - Locate within resident's reach.
  - Orient resident regularly to use of the call light.

## **TV, RADIO**

- Television, radio - consider a remote control for the resident likely to fall if they get up unassisted.

## **INTERPERSONAL PREFERENCES**

- Preference in terms of care provider: For example, there were several examples of male residents not wanting a male to provide care. When a male did provide care, the resident became combative. When asked, the male resident explained he did not want a male to see him being dependent.
- Identify people near the resident when the disruptive behavior occurs. Another resident or staff person may set off the behavior.

## Family

- Tell the family about resident's current condition.
- Teach the family about behavior changes that result from cognitive loss.
- Help the family be realistic about the resident's abilities.
- Involve the family in the behavior management plan.
- Inform the family of nursing home policy.
- Assist family to understand state and federal regulations affecting LTC, hospitals, and the differences.

# WANDERING

***FIRST COMPLETE BASIC ASSESSMENT TO RULE OUT MEDICAL ILLNESS BEFORE PROCEEDING WITH THIS SECTION.***

## Medications

### **DOSAGE - MULTIPLE DOSAGES/MULTIPLE MEDICATIONS**

- Seniors usually require 1/2 - 2/3 of the normal dose especially there is a hepatic/renal disease, low body weight, and malnutrition.

### **CHECK DRUG SUBSTITUTIONS, INTERACTION, SIDE EFFECTS - psychotropics, diuretics, cardiovascular**

- Be aware that for institutionalized individuals the greater risk of falls is in the first six weeks, however, the risk remains somewhat higher for the first six months.
- Evaluate medications for drug toxicity
- Some residents may be toxic at therapeutic levels, while other residents may be at therapeutic levels when medication is below usual accepted range.
- Psychotropics
  - Recommend to physician avoidance of long-acting barbiturates and benzodiazepines and limit other sedatives/tranquilizers if indicated, for example PRN.
  - Have residents void before receiving tranquilizers/sedatives
  - Do not hold back medication if physician feels it is indicated. Depression and psychosis are as real as physically observed disabilities.
- Diuretics
  - Offer frequent toileting assistance if diuretics are used
  - Minimize use of diuretics at bedtime
  - May cause hypotension
  - Will require electrolytes, BUN, and creatinine at least every 6 months to monitor renal status
- Cardiovascular
  - Monitor residents for orthostatic dizziness
  - Watch for signs of weakness or fatigue - taking anti-hypertensives?
  - Many cardiac medications after Heart Rate.
  - Teach resident to rise slowly from a sitting or lying position

### **HAVE ANY MEDICATIONS BEEN ADDED TO REGIMEN WHICH MAY INCREASE FALLS?**

- Benzodiazepine, psychotropics, anti-convulsants/mood stabilizers, cardiovascular meds

### **DIGITALIS LEVELS**

- Heart rate that is dramatically fast or slow decreases the efficiency of the heart resulting in hypoxia to vital organs including the brain.

## **DILANTIN™ LEVEL VPA(VALPROIC ACID) TEGRETOL™**

- May cause sedation and dizziness even at therapeutic levels. Disorientation may be experienced as well as nausea. These medications require CBC and liver function tests every 6 months.

## **SMA 6 (BLOOD CHEMISTRY PANEL)**

- Elevated BUN with creatinine may indicate renal failure or dehydration. Electrolytes (Na, K, Cl) are important in muscle contractibility - includes the cardiac muscle

## **VOID BEFORE GIVING TRANQUILIZERS / SEDATIVES**

## **FREQUENT TOILETING ASSIST IF ON DIURETICS**

## **LIMIT LONG-ACTING BENZODIAZEPINES**

- When possible, Ativan™ is a popular short-acting benzodiazepine.

## **ADMINISTER PAIN MEDICATIONS BEFORE ROM AND TRANSFER**

- Non-Steroidal Anti-Inflammatory drugs are useful, but these drugs continue to have a higher incidence of gastrointestinal, hepatic and renal side effects. An acetaminophen may be a better choice for osteoarthritis. Use adequate pain meds to include narcotics in proper dose. Addiction is not an issue in this population. Be watchful for sedation and CONSTIPATION.

## **Dementia / Alzheimer's Disease**

- Exit Seekers
  - Barriers where wandering residents should not go - Try to blend things into wall when you do not want the resident to focus on them, e.g.; exits.
  - Visual barriers - Stop signs, yellow ribbons curtains, distract wanderers by wall papering over exits, cover door knobs, use a bookcase to cover doorway, fabric over door handles, mirrors at exits to distract resident from leaving. (Check with Fire Marshall)
  - Use alarm systems and door alarms, wanderguard bands.
  - Secured area outside - include the over 90 non-toxic plants.
  - Use of cueing for recognition of room, appetite, and toileting
  - use symbols, signs, photos to direct.
  - If patient is not agitated, unhappy, a danger to themselves or other residents, use above suggestions to provide a safe environment and allow them to wander. This behavior is characteristic of Alzheimer type dementia; it may cause more agitation to resident if behavior is not tolerated.
  - If wandering interferes with nutrition, use finger foods that resident can eat while walking.
- Cognitively disabled residents may express depression by anxiety and excessive pacing.

## **ATTITUDE/APPROACH**

- Remain calm. Do not overreact to behavior.
- Stay flexible and non-resistive.
- Guiding (not controlling)
- Be patient and stay neutral.



## VERBAL APPROACHES

- Use concrete, exact, positive phrases and repetition of the same phrase to trigger an automatic response - anchor response to words, gestures, or colors, and ask resident to repeat command.
- Use one step commands which are simple.
- Need to assess whether to offer the resident a choice. Give a suggestion or a command if unable to offer a choice. When possible, offer choices of where to eat, when to do grooming, bathing, etc. If the resident feels a lack of control, he or she may become aggressive. At times, too many choices may be confusing, so limit choices. For example, "Would you like cereal or toast?"
- Use calm, soft, slow voice pattern. Say one question at a time and wait for a response.
- Avoid arguing or reasoning.
- Eliminate distractions.
- Keep your promises, so only make promises that you will be able to follow through.
- When the resident is present, include them in the conversation.
- Identify resident's vocabulary and use it. A very old, demented person is unlikely to understand explanations of HMO's, current new medical practices, or slang expressions. A demented person does not acquire new information well. Rely on their experiences as a younger adult.
- Treat resident as an elder, not as a child.
- Validate resident's feelings.
- Give directions within attention span. If resident is too confused or combative, always come back later.
- Verbal and non-verbal messages should match. Stand in front of person and make eye contact.
- Use the resident's name frequently.
- Assess whether the resident responds better to verbal or non-verbal messages. For example, a resident who might become combative when told verbally to use the walker may accept assistance if shown non-verbally how to use walker.
- The resident is already impaired, but how staff communicate with the resident may increase his/her disability. For example, the staff say "don't go outside," which may be

confusing to a demented resident. It is far more effective and skillful to tell the resident exactly what you want them to do in slow, concise, and concrete sentences, such as: "Stay in the building" or "Walk with me." A nurse aide told a resident to "Hop in bed" and the resident tried to do it, and said, "I can't." The reason why confused residents pull the fire alarm is because "Pull" is clear and concise, while "In case of emergency" does not register.

- Residents with short term memory problems may confuse current requests with requests and occasions from their past. For example, "Mother never let me do that," or "I have told you children not to mess with that door," etc. With some residents, you can observe a transfer in personality traits. They will speak as if they were their parents, children, or teachers. You may improve communication with them if you find out who you are talking to and what the agenda is for that person.
- Make sure to speak in primary language. Seek help of translator if primary language is other than English or a language in which you are not proficient. If a relative is the translator, schedule care planning around when relative may be present to explain care and procedures.
- Do not use words such as "on," "below," "beside," or "between." These words are difficult for dementia patients to understand.
- If the person is having difficulty finding the right word, supply the word for him. This helps limit his or her frustration.
- When you do not know what the individual means, ask him or her to point to it, describe it, or to show you how it works.
- Use other signals besides words to convey what you mean - point, touch, or demonstrate.
- Talk to the impaired individual and make a point of telling him or her what you are doing and why.
- Break down complex tasks into single steps. Show the resident how to begin.
- Make sure the person's clothing and articles of toileting do not require motor skills the resident no longer has.
- Provide opportunities for the resident to succeed in activities that she can still do.

### **NON-VERBAL APPROACHES**

- Know that your attitude/mood is contagious and felt by all - practice smiling, looking
- open and friendly and listening. Show a positive attitude.
- Assume an equal or lower position, especially if the resident feels powerless.

- Move and speak slowly.
- Avoid overwhelming the resident physically or verbally - approaching an anxious resident with three or more people may lead to a catastrophic reaction. Do not call out or surprise resident from the rear where they cannot see.
- Be respectful.
- Make sure that your actions match your verbal message.
- Exaggerate your expressions if they are helpful in getting a message across.
- Learn likes and dislikes, family situation, communication style, past behavior problems, preferred routines and habits.
- Learn sources of comfort or discomfort.
- Learn three things that give the resident comfort.
- Do not force the resident to do anything when she will not cooperate.
- Anticipate the resident's needs during care.

### **DISTRACTION THERAPY**

- Get them to talk about where they are going and ask questions about home, family, etc.
- Look for possible reasons for behavior - overstimulated, need to exercise, looking for something, hungry, or need to go to the bathroom.
- Structured walked indoors or outdoors.
- Buddy system.
- Develop activities to provide freedom from restraints.
- Need for companionship and supervision
  - Use the buddy system - have staff other than nursing go for a daily walk with resident.
  - Get volunteers involved in walking with residents.
  - Encourage relationships between residents who may have compatible interests.
- Is a secured area available for people who may wander from the facility?
- Limit distractions in the room while giving care
- Use distraction to keep the resident interested in something else during an activity that causes behavior problems.

- Distraction Therapy
  - Use of mobiles
  - Use of family videos, picture collages, scrapbooks
  - Use of Mirror

## **Environment**

### **MUSIC THERAPY**

- Music can assist with de-escalating a resident
  - For example, one resident loved classical music. The staff discovered that if they turned her radio to a classical music station just as she begins to escalate, she will relax and take a nap instead of trying to leave the building.

### **RECREATION**

- Recreation Therapy
  - Residents who are involved in activities will usually not try to get up, so this should be a restraint-free time each day.
  - Restructure activities so residents who are not confused or only slightly confused are in one group and cognitively impaired are in small group activities or one-to-one activities.
  - Use volunteers for one-to-one activities.
  - Sensory stimulation - Select specific sensory experiences geared for their enjoyment. For example, an angora sock massage or blow dryer massage.

### **EXERCISE**

- There should be a planned daily exercise program.
- Schedule periods of physical activity.
- Provide time for rest throughout the day.

### **LABELING**

- Use high contrast black and white pictures.
- Repeat labels often to remind residents of the location of rooms.
- Place all labels at a level that can be seen from a wheelchair or in a lower posture.
- Develop an emergency plan to retrieve residents found missing from the unit

# MEDICAL NECESSITY

***FIRST COMPLETE BASIC ASSESSMENT TO RULE OUT MEDICAL ILLNESS BEFORE PROCEEDING WITH THIS SECTION.***

## To prevent interference with Tubing/Life Support

- I.V.:
  - Cover site with Kerlix
  - Soft sponges in hands
- Evaluate for elimination of bothersome treatment - remove catheter or change from an I.V. to gastrostomy tube or spoon feeding. However, do not remove catheter without a primary care provider order. A patient may need a catheter because of urinary retention or obstruction.
- Ask the resident what is going on - For example, one resident was pulling out his tubes. When asked about what was bothering him, he replied that he was experiencing hallucinations. When the medication was discontinued, he stopped pulling at his tubes.
- Gastrostomy: Abdominal Binder/Band
- Foley: Sweat Pants
- NG: Air splints on arms

## Pharmacological

- Oversedation/Undersedation: evaluate for excessive dose, excessive duration, adequate monitoring, indications for use and presence of adverse consequences.

## BIBLIOGRAPHY

1. Avorn, J., & Langer, E. (1982). Induced disability in nursing home patients: A controlled trial. Journal of the American Geriatrics Society, 30(6), 397-400.
2. Barbieri, E. B., (1983). Patient falls are not patient accidents. Journal of Gerontological Nursing, 9(3), 165-173.
3. Bernal, E. W., (1983). Immobility and the self: A clinical-existential inquiry. Journal of Medicine and Philosophy, 9(1), 75-91.
4. Blakeslee, J. A., Hunt, A. R., Thankachan, G. & Torell, C. A. (1986). Physical restraints: A dilemma in long term care. Proceedings of the Gerontological Society of America Annual Conference, Chicago; GSA.
5. Bortz, W. M. (1982). Disuse and aging. Journal of the American Medical Association, 248(10), 1203-1208.
6. Branzelle, J. (1988). Provider responsibilities for care of wandering residents. Provider, 14(2), 22-23.
7. Brody, E., Kleban, M., Lawton, M. P. & Silverman, H. (1971). Excess disabilities of mentally impaired aged: Impact on individualized treatment. The Gerontologist, 2, 124-133.
8. Calfee, B. E., (1988). Are you restraining your patients' rights? Nursing 88, 18(5), 148-149.
9. Care that kills. (1987, June). Press-Telegram Special Report.
10. Cohen-Mansfield, J. (1986). Agitated behaviors in the elderly. II. Preliminary results in the cognitively deteriorated. Journal of the American Geriatrics Society, 34, 722-727.
11. Costa, L. (1989). Falls in the nursing facility. Contemporary Long-Term Care, 12(12), 92.
12. Costa, Lori (1989). Residents' rights and the use of restraints under OBRA. Contemporary LTC, (8), 48.
13. Cotsides - protecting whom against what? (1984). Lancet, 2, 383-384.
14. Crandall, L. (1986). Prevention and Management of agitated aggressive behavior in older adults. Salem, Oregon: Oregon State Hospital.
15. Cushing, M. (1985). First, anticipate the harm . . . American Journal of Nursing, 85, 137-138.

16. DiMaio, V. J., Dana, S. E., & Bux, R. C. (1986). Deaths caused by restraint vests. (Letter to editor). Journal of the American Medical Association, 255(7), 905.
17. Downs, F. S. (1974). Bedrest and sensory disturbances. American Journal of Nursing, 74(3), 434-438.
18. Dube, A. H., & Mitchell, E. K. (1986). Accidental strangulation from best restraints. Journal of the American Medical Association, 256(19), 2725-2726.
19. Engle, G. L. (1968). A life setting conducive to illness: The giving-up, given-up complex. Annals of Internal Medicine, 69(2), 293-300.
20. English, R. A. (1989). Implementing a non-restraint philosophy. The Canadian Nurse, (3), 18-22.
21. Epstein, C. E., & Sadowick, P. M. (1989). Specialized seating for the institutionalized elderly, Scientific Technical Session 104-A. Technology Review of 1989, American Occupational Therapy Association, Rockville, MD. 13-16.
22. Evans, L. & Strumpf, N. (1989). Tying down the elderly: A review of the literature on physical restraint. Journal of the American Geriatrics Society, 37, 65-74.
23. Evans, L. K., Strumpf, N. E., & Williams, C. C. (In Press). Redefining a standard of care of frail older people: Alternatives to routine physical restraint. In R. Kane, P. Katz, & M. Mezey (Eds.), Advances in long term care, Vol I (70 pages). New York: Springer.
24. Folmar, S. & Wilson, H. (1989). Social behavior and physical restraints. The Gerontologist, 29(5), 650-653.
35. Francis, J. (1989). Using restraints in the elderly because of the fear of litigation. The New England Journal of Medicine, 320(13), 870-871.
26. Hall, G. R. & Buckealter, K. C. (1987). Progressively lowered stress threshold: a conceptual model for care of adults with Alzheimer's disease. Archives of Psychiatric Nursing, 1(6), 399-406.
27. Halpert, A., & Connors, J. P. (1986). Prevention of patient falls through perceived control and other techniques. Law, Medicine & Health Care, 14(1), 20-24.
28. Harris, S. (1985). The use and misuse of restraints. American Health Care Association Journal, 11(8), 45-46.

29. Harper, C. M. & Lyles, Y. M. (1988). Physiology and complications of bed rest. Journal of the American Geriatrics Society, 36, 1047-1054.
30. Hussain, R. A. & Davis, R. L. (1985). Responsive care: behavioral interventions with elderly persons. (p. 86) Champaign, Illinois: Research Press.
31. Kapp, M. B. & Bigot, A. (1985). Medicolegal problems in caring for nursing home residents. Geriatrics and the Law (pp. 128-129). New York: Springer Publishing.
32. Katz, L. (1987). Accidental strangulation from vest restraints. (Letter to the editor). Journal of the American Medical Association, 257(15), 2032-2033.
33. Kendall Corporation. Untie the Elderly - Philosophy and Purpose. Kennet Square, PA.
34. Kendall-Crosslands. Use of restraints. Kennet Square, PA.
35. Knapp, Marshall (1989). Aggressive residents and families. Journal of Long Term Care Administration, 12-17.
36. Kopac, C. A. Establishing a restorative nursing program in LTC facilities. Contemporary Long Term Care, (6), 28-29.
37. Mace, N. (1984). Facets of dementia. Journal of Gerontological Nursing, 10(2), 34.
38. Mace, N. Programs and services which specialize in the care of persons with dementing illnesses - Issues and options The American Journal of Alzheimer's Care and Research, May/June 1987, 10-17.
39. Masters, J. & Marks, S. F. (1990). The use of restraints. Rehabilitation Nursing, 15(1), 22-25.
40. May, K. (1989). Restraints and the law. Nursing Homes, 8-9.
41. McHutchion, E. & Morse, J. M. (1989). Releasing restraints: A nursing dilemma. Journal of Gerontological Nursing, 7(2), 16-21.
42. McLardy-Smith, P., Burge, P. D., & Watson, N. A. (1986). Ischaemic contracture of the intrinsic muscles of the hands: A hazard of physical restraint. Journal of Hand Surgery, 11(1), 65-57.
43. Menten, J. C. & Ferrario, J. (1989). Calming aggressive reactions: A preventive program. Journal of Gerontological Nursing, 15(2), 22-27.
44. Mercer, S. & Kane, R. A. (1979). Helplessness and hopelessness among the institutionalized aged: An experiment. Health and Social Work, 4(1), 91-116.
45. Miller, M. (1975). Iatrogenic and nursigenic effects of prolonged immobilization of the ill aged. Journal of American Geriatrics Society, 23(8), 360-369.



46. Mion, L. G., Frengley, J., Dermot, M. B., Jakovcic, C. A., & Marino, J. A. (1989). A further exploration of the use of physical restraints in hospitalized patients. Journal of the American Geriatrics Society, 37, 949-956.
47. Mitchell-Pederson, L., Edmund, L., Fingerote, E., & Powell, C. (1986). Reducing reliance on physical restraints. Today's Nursing Home, 7(2), 40-46.
48. Moss, R. J. & LaPuma, J. (1991). The ethics of mechanical restraints. Hastings Center Report, January-February, 1991, 22-24.
49. Myers, A. H., Baker, S. P., Robinson, E., Abbey, H., Doll, E. T., Levenson, S. (1989). Falls in institutionalized elderly. Journal of Long Term Care Administration, 17(4), 12-18.
50. Northrop, C. E. (1987). A question of restraints. Nursing 87, 17(2), 41.
51. Omnibus Budget Reconciliation Act (OBRA) (1990). Regulations and Interpretive Guidelines, Health Care Financing Administration.
52. Oster, C. (1976). Sensory deprivation in geriatric patients. Journal of the American Geriatrics Society, 24(10), 461-464.
53. Pear, R. (1989, January 17). New law protects rights of patients in nursing homes. The New York Times, pp.1, 18.
54. Powell, C. Mitchell-Pederson L., Fingerote, G., & Edmund L. (1989). Freedom from restraint: consequences of reducing physical restraints in the management of the elderly. Canadian Medical Association Journal, 141. September, 15, 561-564.
55. Rader, J., Doan, J. & Schwab, M. (1985). How to decrease wandering, a form of agenda behavior. Geriatric Nursing, 6, 196-99.
56. Rader, Joanne (1987). A comprehensive staff approach to problem wandering. The Gerontologist, 27(6), 756-760.
57. Rader, Joanne (1991). Modifying the environment to decrease the use of restraints. Journal of Gerontological Nursing, 17(2), 9-13.
58. Rights in nursing homes. (1989, February 1). St. Petersburg Times, p. 16A.

59. Rubenstein, H. S., Miller, F. H., Postel, S., & Evans, H. (1983). Standards of medical care based on consensus rather than evidence: The case of routine bedrail use for the elderly. Law, Medicine and Healthcare, 11(6), 271-276.
60. Schafer, A. (1985). Restraints and the elderly: When safety and autonomy conflict. Canadian Medical Association Journal, 132, 1257-1260.
61. Schwab, M., Rader, J., & Doan, J. (1985). Relieving anxiety and fear in dementia. Journal of Gerontological Nursing, 11(5), 8-15.
62. Shindul, J. A. & Snyder, M. E. (1981). Legal restraints on restraint. American Journal of Nursing, 81(2), 393-394.
63. Strumpf, N., Evans, L., & Schwartz, D. (1987). Patterns of restraint: A cross-cultural view. Paper presented at 40th annual scientific meeting of Gerontological Society of America, Washington, D.C.
64. Tideleiksaar, R. (1984). An assessment form for falls. Journal of American Geriatrics Society, July 1984, 538-539.
65. Werner, P., Cohen-Mansfield, J., Braun, J., & Marx, M. (1989). Physical restraints and agitation in nursing home residents. Journal of the American Geriatrics Society, 37(12), 1122-1126.
66. Zgola, J. M. (1987). Doing things. A guide to programming activities for persons with Alzheimer's disease and related disorders. Baltimore: Johns Hopkins University Press.

## AGENCY RESOURCE LIST

**ALZHEIMER'S ASSOCIATION**

789 SHERMAN STREET, SUITE 500  
DENVER, CO 80209

DENVER AREA: 303-813-1669  
TOLL FREE: 800-864-4404

**COLORADO ASSOCIATION OF HOMES AND SERVICES FOR THE AGING**

1888 SHERMAN STREET, SUITE 610  
DENVER, CO 80203

303-837-8834

**COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT**

HEALTH FACILITIES DIVISION  
4300 CHERRY CREEK DRIVE SOUTH  
DENVER, CO 80222

303-692-2800

**COLORADO FOUNDATION FOR MEDICAL CARE**

2851 SOUTH PARKER ROAD, SUITE 200  
AURORA, CO 80014

DENVER AREA: 303-695-3300  
TOLL FREE: 800-950-8250

**COLORADO HEALTH CARE ASSOCIATION**

225 EAST 16<sup>TH</sup> AVENUE, SUITE 1100  
DENVER, CO 80203

303-861-8228

**HEALTH CARE FINANCING ADMINISTRATION**

DENVER REGIONAL OFFICE  
1961 STOUT STREET, 5<sup>TH</sup> FLOOR  
DENVER, CO 80294

303-844-4024

**OFFICE OF THE STATE OMBUDSMAN**

455 SHERMAN STREET, SUITE 130  
DENVER, CO 80203

303-722-0300

## AGENCY RESOURCE LIST - CALIFORNIA

### ALZHEIMER'S ASSOCIATION

WEBSITE: [www.alz.org](http://www.alz.org)

TOLL FREE: 800-660-1993

*Call for the number of your local California Chapter. Provides information, support, and assistance on issues related to Alzheimer's Disease.*

### CALIFORNIA ASSOCIATION OF HEALTH FACILITIES

2201 K STREET

P.O. BOX 537004

SACRAMENTO, CA 95853-7004

WEBSITE: [www.cahf.org](http://www.cahf.org)

916-441-6400

FAX: 916-441-6441

TOLL FREE: 800-347-5547

*Long term care professional association representing profit and not-for-profit skilled nursing facilities, residential care facilities for the elderly, intermediate care facilities, mental health rehabilitation centers, and facilities for the developmentally disabled.*

### CALIFORNIA ASSOCIATION OF HOMES AND SERVICES FOR THE AGING

7311 GREENHAVEN DRIVE, SUITE 175

SACRAMENTO, CA 94831-3572

WEBSITE: [www.aging.org](http://www.aging.org)

916-392-5111

FAX: 916-392-0575

*Long term care professional association representing not-for-profit organizations providing housing, health care, and community services to the elderly.*

### CALIFORNIA DEPARTMENT OF AGING

OFFICE OF THE STATE LONG TERM CARE OMBUDSMAN

1600 K STREET

SACRAMENTO, CA 95814

WEBSITE: [www.aging.state.ca.us](http://www.aging.state.ca.us)

916-323-6681

FAX: 916-323-7299

SENIOR SERVICES

INFORMATION LINE: 800-510-2020

*Investigate and attempt to resolve complaints made by, or on behalf of, individual residents in California long term care facilities, including skilled nursing facilities, residential care facilities for the elderly, intermediate care facilities, adult residential care facilities, and adult day health care facilities.*

### CALIFORNIA DEPARTMENT OF HEALTH SERVICES

LICENSING AND CERTIFICATION PROGRAM

1800 THIRD STREET, SUITE 210

P.O. BOX 942732

SACRAMENTO, CA 94234-7320

WEBSITE: [www.dhs.ca.gov/lnc](http://www.dhs.ca.gov/lnc)

916-445-2070

FAX: 916-445-6979

L&C PROGRAM

INFORMATION HOTLINE: 800-236-9747

*Responsible for licensing and regulating all health facilities in California, including hospitals, skilled nursing facilities, adult day health care centers, and clinics.*

**CALIFORNIA DEPARTMENT OF SOCIAL SERVICES**

COMMUNITY CARE LICENSING DIVISION

744 P STREET, MS 17-17

SACRAMENTO, CA 95814

WEBSITE: [www.dss.cahwnet.gov](http://www.dss.cahwnet.gov)

916-657-2346

FAX: 916-657-3783

*Responsible for licensing and regulating all community care facilities in California, including adult day care facilities, adult day support centers, adult residential facilities, and residential care facilities for the elderly.*

**CALIFORNIA HEALTHCARE ASSOCIATION**

1201 K STREET, SUITE 800

P.O. BOX 1100

SACRAMENTO, CA 95812-1100

WEBSITE: [www.calhealth.org](http://www.calhealth.org)

916-443-7401

FAX: 916-552-7596

*Professional association representing California hospitals and health systems.*