### Possible Interventions in the Care Plan:

**Approach:** See Communication Tip Sheet ([http://goo.gl/GPpqW3](http://goo.gl/GPpqW3))

#### For Wandering (also known as “exploring”):

- Identify individual rooms by “familiar items”, or those with special meaning for the patient, on the doorframe. Make the item 3–D and **at their eye level**, so it can easily be seen from down the hall. Do not put the item flat against the door or wall. Examples include a flower, a large bow, or a small flag.

- If someone is wandering into another patient's room try to determine why their walking path ends up there. Is it at the end of the hall? Is there a comfortable chair nearby? Could they be looking for someone or for the bathroom? Is their room so cluttered that they can't get to a chair to their room to sit?

- Sometimes placing a dark mat outside the door may discourage them from leaving the room because they may perceive it as a hole.

- Use pictures, a clock, a table lamp, a nice bedspread, a CD player, etc. to make patients’ own rooms more appealing.

- Consider whether a patient should be part of a walking program or if they need a stroll/activity.

- Toilet a wandering patient regularly, and be specific as to the time schedule in their care plan.

- Note time of day when most wandering occurs. What is Behavior Tracking telling you? Target care plan activities for the time when most wandering is happening. Adjust (quiet) activity schedules to provide extra support / activities at that time. Suggest family visits at this time of day. Offer refreshments/ snacks at this time. Consider 1:1 intervention such as reminiscence equally as important as doing a dressing change.

- Provide a “busy box” or activity if you think it will help alleviate boredom. Ask the family what the patient enjoys talking about, looking at, etc.

- A yellow door barrier has met with some success, but does not always work. A door barrier the same colour as the doorframe may work better. Use a **Keep Out** sign
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- Draping a doorknob bell over the doorknob can alert staff when a patient opens their bedroom door at night. If doorknobs are round, a childproof plastic door knob cover may help.

- Provide a safe wandering path. Is there somewhere the patient can go safely for a walk?

- Is a medication making them restless? Check the side effects.

- Secure unit needed? Bed alarm needed? Short term use of PSW (helps on unit + keeps eye on patient)

- Sometimes the physiotherapist may do “exercises” with a patient at the time when that patient is most likely to wander

- Occupational Therapy may be able to design a unique busy board, such as an electrical board for a retired electrician.

- Recreation Therapy may be consulted for ideas that the patient could do independently based on ability and Life Story.

For Aggression with Personal Care:

- Try to determine why the patient is being aggressive. Use the acronym DO CAREPLAN to find an answer. Perhaps the patient has a delusion that you are trying to harm him/her and they “have to” escape? Do they have a delirium? Are they depressed? Is a benzodiazepine like Lorazepam making their confusion worse? (Sometimes it is the medication making the behaviour worse.) Never assume that because a medication has been ordered that it is the RIGHT or BEST medication for someone who is elderly/ frail with dementia.

- Strength is not in the number of care providers. Fewer is better and ideally 1–2 at the most to do a bed bath. If safety is a concern on a daily basis then ask WHY the patient is aggressive. May need to use a medication like an antipsychotic for Severe/daily aggression. Avoid Ativan (Lorazepam) if possible.

- Is arthritic pain restricting range of movement? The patient may need pain medication before personal care.

- Ask the family what the patient’s “usual routine” was at home.

- Don’t pressure the patient to accept personal care. Timing not right? Try again later, perhaps in the afternoon. For example, break up bath into small tasks through the day. Prioritize areas that need to be washed and do other areas later or not at all.
• Cover the patient with a warm flannel bath blanket during their bath. Only uncover the part that is being washed so they aren’t chilled.

• Allow the patient to do as much as they are able to for self, even if it’s just washing their face.

• Explain all care to the patient one step at a time before doing it.

• Try to engage the patient’s help. “Could you help me by holding onto the bed rail?” “Can you wash your face for me?” Thank them for helping you.

• Before doing something, such as a turn, tell patient what you are going to do and then make sure they have processed this information BEFORE the turn.

• Share “secrets of care” with other providers. “This worked for me when I gave Mr. Jones his bath...”

• Calm caregiver approach = avoid “words that wither”. See Communication Tips – https://library.nshealth.ca/HospitalElderCare/Communication

• Allow ample time for bathing. Rushing does not give the patient time to absorb the whole process.

• You may have to divide up personal care. Try doing part of the care while the patient is in bed and finish the rest after lunch when the patient is sitting up in a chair.

• Reassurance and good eye contact (lower to their eye level)

• Don’t talk above patient to another staff member as if patient is not in room. Only one primary person does the talking during care so it is less confusing for the patient.

For Repetitive Calling Out:
(There are no medications that eliminate calling out.)

• When is calling out the worst? Use Behavior Tracking to tell you. Target interventions at the times when the calling out is especially frequent.

• WHY is the behaviour happening? Is this a delirium? Is the patient depressed? What exactly are they saying when they call out? Use acronym DO CAREPLAN to find answer.

• Is there an underlying anxiety that requires reassurance? Sometimes depression presents as anxiety and an antidepressant may help. Unfortunately, an antidepressant may take 3–5 weeks to work but it can still be worth a try.
- Are they on a medication that will only make the behavior worse like too much Benadryl? Too much Gravol? Are they on something very anticholinergic? Is the Lorazepam or Quetiapine making their behaviour worse? If it is not helping, then why continue it?

- Try to make sense of what the person is calling out for. For example, "Annie" could have been a childhood doll; "Albert" may be an old friend.

- Is there an "unmet need" (boredom / lonely / pain / shoes too tight / poor sleep/ hungry/ cold/ have to use the bathroom)?

- Note times that the patient is quieter; what is different? Is there less/more activity around them at these times?

- Repetitive, simple motor activity can be helpful (for example, fingering a macramé craft, folding socks, folding facecloths, listening to favourite music, a hand muff etc.)

- Wrap shoulders, back, and arms in a warm flannel blanket when calling out is especially loud or frequent.

- Give the patient time to respond to your questions.

- Sit down at eye level. If you lower your voice level, the patient sometimes will lower their voice level too. Use slow speech and low toned voice. If they are yelling, don’t speak back to them in a loud voice. Try to get them to mimic your noise level and tone. Use their Life Story to engage them. Have regularly scheduled 1:1 time with individual (sit in close proximity) in care plan and engage them in a conversation / activity with you while you chart.

- Play their favourite music, rather than your own. Ask the family what the patient prefers. Ask the family to bring in a CD player with the patient's favourite CDs.

- Family videos from the past (can use a portable DVD player) or ask family to visit when calling out is worse

- Include in activities with Recreation Therapy (Therapeutic Assistant) if possible