THE MANAGEMENT

OF WANDERING

IN OLDER PEOPLE WITH

DEMENTIA

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POWYS HEALTH CARE NHS TRUST

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ACKNOWLEDGEMENTS

I should like to thank all the patients and carers who participated in this study. Without their involvement and support this study would not have been possible.

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INTRODUCTION

The syndrome of Dementia is characterised by abnormalities in cognitive function. The changes in behaviour which often accompany the syndrome present major problems for both patients and carers and frequently necessitate patients being taken into institutional care (Argyle et al, 1985).

One of the most important of behavioural changes in Dementia is wandering. Despite being identified as a major problem for carers and nursing staff alike (Rabins, cited by Hope & Fairborn, 1990) it is a subject which has generated little study (Mayer & Darby, 1991). Risks associated with wandering include the potential for encountering hazards, falls and fractures, opportunities for missed treatments and diversion of nursing staff from other duties (Mayer & Darby, 1991. The actual risk of experiencing a hazardous outcome from wandering is unknown (Algase, 1992a).

Definitions of wandering

Hope & Fairburn (1990) cite several definitions of the term:

“A tendency to move about either in a seemingly aimless or disoriented fashion, or in pursuit of an indefinable or unobtainable goal.” (Stokes)

“Frequent and/or unpredictable pacing with no discernible goal.” (Dawson)

“Wanderers are patients with navigational difficulties.” (de Leon)

Whatever the definition, ward staff and carers are faced with the conflict between safeguarding the wanderer from potential serious harm and ensuring their right to move freely.

Traditional care of wandering patients

Historically, the most popular way of coping with wanderers relied heavily on restraints, physical as well as pharmacological (Snyder et al, 1978), which relieved staff members from dealing with behavioural problems.

Algase (1992a) quotes that as far back as 1889 an English magistrate challenged an edict that “all wandering lunatics be taken before the police and charged”, proposing instead examination by the workhouse physician prior to any court appearance.

Such practices are now largely viewed as inappropriate as, ethically, restraints violate the rights and dignity of the wanderer. Studies have shown that more injuries or falls are caused when restraints are used than when they are not (Strumpt & Evans, 1998.

As wandering remains a major management problem, this study intends to review the literature on “Wandering” and test some of the non-invasive and non-restrictive strategies identified that could help to deter wandering without using restraint, in the hope of improving my current professional practice and the care provided within the unit.
CURRENT PRACTICE

Tawe Unit
I work on an eight bedded Elderly Mentally Ill Assessment Unit which also houses a
day hospital, Monday to Friday, for up to six patients daily. This unit forms part of a
small but busy community hospital. The unit policy and guidelines on restraint
closely reflect those laid down by the RCN (1998).

The core of the hospital is circular in appearance with corridors leading from this to
wards and departments. As a result of this layout, there are no doors to lock or
baffle locks in use. The door at the main entrance to the unit is controlled
electronically, and opens automatically as you approach it onto a very busy
thoroughfare (which really causes problems). The door is only locked at night for
security purposes.

The only doors on the unit are fire doors and fire exits. All chairs on the unit are
lounge types with no mechanical forms of restraint. Cot sides are used only for hose
whose condition requires them to be nursed in bed. Drug regimes are closely
monitored by both medical and nursing staff, ensuring that medication is used for a
specific purpose and not as a chemical restraint.

The unit has no long-term beds but offers assessment, respite and day care for older
people with mental health problems, the majority suffering from dementia, with an
average stay of two weeks.

The model of nursing in use is the unit’s own adaptation of Neuman’s
System/Ropers et al.’s Activities of Daily Living Model. The Clifton Assessment
Procedure for the Elderly (CAPE) is also used. Although we find these tools
appropriate for assessing our client group, there is no reference to ‘wandering’ to be
found in them. All patients are both physically and mentally assessed.

The wandering patients tend to wander down the corridors, through the fire doors,
ono to neighbouring wards and down to the main entrance. Very rarely do they
approach the fire exit (the reason for this remains a mystery to us).

How we deal with wandering at present:
1. *Structured day:* Stokes (1988) believes that the provision of interest and
   companionship may prevent wandering occurring. With help from the
   occupational therapy healer, a programme of daily activities is devised.
   Unfortunately, the dementing patient has a limited attention span, so this does
   not keep them occupied for very long.

2. *Exercise:* whenever possible, staff take patients for a walk around the
   hospital and the grounds, but we find the wanderers, who have seemingly
   limitless energy, are off wandering again the minute they are back on the
   unit.

3. *Distraction:* the aim is to the dementing patient to forget his/her intention
to wander and divert them to another activity.
4) **Collusion:** accompanying the wanderer, who is usually searching for someone or something, until the situation is diffused.

Collusion is the method we tend to use most. As many of our wanderers refuse to stay or return to the unit, we tend to accompany them, which can mean spending most of the shift ourselves, wandering around the hospital.

After their two week stay, we send them home to their carer, ignoring how the carers cope with the problem of wandering, mainly because we believe that the patient is much happier and settled in their own environment. This is most certainly not the case.

Recently I asked carers of identified wanderers how they cope. They all tended to agree that the weather plays a great part in it. Here are some of the comments:

"*When the weather is fine, I can take my wife for a walk."

"*I lock the front door, leaving the back door open, so he can wander into the garden."

"*I rely on neighbours, if she wanders off, to bring her back."

"*I have to lock mum in when I peg washing out or pop to the toilet."

When the weather is bad, they all agreed, that this caused them the greatest difficulties. They stated that they had to lock all the exit doors and rely mostly on medication, increasing the dose as needed. Night-time wandering rarely was a problem, because again they relied on medication. One carer stated:

"*I don't know how I would cope without day care and regular respite care, he would probably have to go to a Nursing Home."

How do carers perceive how the nursing staff manage wandering; one carer became very angry when his wife wandered out of hospital and found her way home. His response was that he thought his wife was safe in hospital, because we could lock her in!

As about half our current patients with dementia are wanderers, I believe it to be a major problem for both ward staff and carers alike.

**Responding to identified need**

Although our current practice is research-based, there is room for improvement. I took this opportunity to review the available literature and concentrate on two main areas that could be improved:

a) Assessment of Wandering.

b) Ways to deter wandering without restraint.
LITERATURE REVIEW

1. ASSESSMENT

Ballard et al (1991), discovered that there had been no work carried out focusing purely on wandering, however several studies had included wandering as part of a spectrum of behavioural problems. They focused their study on the problems of getting lost within and outside the home, in patients suffering from Alzheimer's Disease, compared with patients suffering from vascular dementia. They also examined the prevalence of getting lost as impairment increased.

They found that in patients with Alzheimer's type dementia there was a greater prevalence of getting lost outside the home in comparison to those with vascular dementia. The findings also suggest that the temporal and parietal lobes, which are more severely affected in Alzheimer's disease, maybe important in getting lost outside the home, as wanderers tend to have more dyspraxia than non-wanderers.

They also found, there was no relationship evident between the prevalence of getting lost outside the home with increased cognitive impairment.

I found this study very interesting, but feel the term "lost", should have been defined, as each carer may define the term differently.

Algase, (1992b), also looked at cognitive discriminants of wandering, but among nursing home residents. Comparisons of wanderers and non-wanderers in this study, revealed significant difference in cognitive skills and lends further support to Ballards et al (1991), study that wandering may implicate parietal lobe pathology.

Norton (1991), investigated the episodes of times, when wandering occurs, looking at the "Sundown Syndrome" as a particularly difficult time of day and explains, "Sunset is commonly associated with tranquillity, but for many other people and their carers, it is a time of turbulence. A distressing phenomenon occurs in some old people with the approach of evening, which is known in the U.S.A. as the ‘Sundown Syndrome’, the appearance or exacerbation of confused and agitated behaviour, a form of delirium, in which calling out and wandering with apparent intent of seeking or ‘escaping’, tend to be marked features”.

The syndrome appears to be confined to individuals with organic brain impairment. She observed thirty-two nursing home residents for four days, and on each day around 3.30 p.m. and 6.30 p.m. noted that a change in behaviour became apparent and, therefore, believed she had witnessed the "Sundown Syndrome".

Although the observation time was very short and the sample very small, these are formidable constraints and probably account for the paucity of the research on the phenomenon. I can, however relate to this syndrome, from my own experience of nursing elderly mentally ill people.

Hope and Fairburn (1990), looked at the term ‘wandering’, believing the term to be vague with no specific meaning. The aim of their study was to describe the range of behaviour covered by ‘wandering’. It was a community-based study and the sample
consisted of people suffering from dementia. The carer of each sufferer was interviewed. From the findings, it was clear that the term ‘wandering’, was used to cover a wide range of quite different behaviours. Any attempt to define ‘wandering’ in general will founder because there is no essence common to all types. A descriptive typology of wandering in dementia was proposed and suggests that behind the various types of wandering there are a number of components, any of which might be operating in a specific patient.

I feel this study would be of great value, when included in our assessment of patients.

2. WAYS OF DETERRING WANDERING WITHOUT RESTRAINT

Namazi et al, (1989), conducted a study on an Alzheimer’s unit, testing seven different visual barrier conditions, for reducing patients exit.

1) No barrier
2) Strips of brown tape, placed parallel to the exit door
3) Strips of beige masking tape, posing minimal colour contrast to the door, placed as number 2
4) Black tape on floor and door base
5) Beige cloth (matching door colour), hiding the door knob
6) Pattern cloth hiding doorknob
7) Beige painted doorknob.

The findings revealed, that of the visual barriers tested to reduce exiting, the concealment of the doorknob behind a cloth panel, irrespective of the colour, was the most successful.

The success of the cloth panel, appears to be the result of visual agnosia. When a door is a solid panel only a doorknob makes it appear different from the adjacent walls. When the knob is concealed, a person with visual agnosia, which is a characteristic of Alzheimer’s Disease, may be unable to interpret the panel as anything other than a dead end. Therefore, visual agnosia, may be utilised as a tool in managing wandering.

I believe that implementing this study would be useful as a deterrent without restraint in the home as well as the hospital setting.

De Ganahl, (1995) used the Detour Doorkeeper in her study as a deterrent/re-director for the cognitively impaired ‘wanderer’. The Detour Doorkeeper is a bright orange, open mesh netting, which is placed across an open doorway (at chest level) and held in place with Velcro.

The idea for the Detour Doorkeeper was taken from the orange netting used as barriers on construction sites. De Ganahl (1995) became interested in the problem of wandering following the admission of one of her clients to a nursing home where the patient’s wandering caused problems with other alert residents. These residents were suffering from a loss of privacy and dignity, harassment and theft from the
‘wanderer’ (who was continually entering their rooms) and as a result the "wanderer" was continually being shouted at by the resident whose room it was.

By placing the net across the open doorway of the residents’ room, De Ganahl found it significantly reduced the number of times the ‘wanderer’ entered the rooms. The researcher suggests it was successful because of the bright orange colour, which the cognitively impaired person perceives as caution, and also because they can find no visual access cues as the net is held in position with Velcro. As a result, the ‘wanderer’ turns away harmlessly.

Again, this strategy could be quite easily adapted to use in the home as well as the hospital setting.

Mayer & Darby (1991) used a full length mirror in their study as a deterrent to wandering, based on observations in a previous study by Mayer-Gross et al, (1977) which suggested that demented patients, are often attracted to mirrors and this is associated with loss of memory of personal identity.

Unobstructive observation of the exit door was undertaken over a two week period with daily alternating use of full mirror, reversed mirror, no mirror. Results suggest that when the mirror was used it significantly reduced exiting in comparison to the results of observations of patients when there was no mirror or the mirror was reversed.

Although the study is preliminary, it could quite easily be used in the home as well as the hospital setting as the mirror is quite harmless and non-custodial.

Barrow & Smith, (1993), looked at something quite different from visual barriers for their responsibility and risk taking project, ‘Electronic Tagging’. Tagging devices activate an alarm, when a sensor worn or carried by an individual passes a detector fitted to a door.

Tagging of elderly people poses major ethical issues. The authors believe that "tagging" should only be used when it can be demonstrated, that alternatives have been considered and have been rejected as unsuitable.

CONCLUSION

Of the literature I was able to find and review, I found them all very interesting and of great value in understanding more about wandering itself and ways of managing it more effectively.

I feel in particular the Descriptive Typology of Wandering in Dementia and the ways of deterring wandering, without restraint (i.e., the mirror, Detour Doorkeeper and camouflage), implemented in the clinical and community setting, would be a great step in improving our current practice.

In the following section I describe how these findings were implemented.
APPLYING THE RESEARCH TO THE PRACTICE SETTING

Over the past year I have worked with a caseload of twenty patients whose ages ranging from 70 years to 93 years old. They are all suffering from the various stages of dementia (moderate, marked or severe cognitive impairment). The majority of them living at home with their carers, the remaining few in local residential /nursing homes. They all have one thing in common - they exhibit the behaviour of wandering.

The following results have been observed:

1) **Assessment**

*The Descriptive Typology of Wandering (Hope & Fairburn, 1990)*

This is proving to be a very useful tool in my clinical area. It has introduced a more systematic method of assessing wandering behaviour and as a result of this we are able to plan care more effectively and incorporate it into individual care plans. It is also helping the hospital/home carers to understand more clearly the variety of behaviours observed in the course of wandering.

2) **Ways of deterring wandering without restraint**

*The Use of Mirrors (Mayer & Darby, 1991)*

The mirrors work quite well in reducing exiting. Of the approaches monitored, I have observed patients talking to their reflection, gazing into mirror for periods of time, using it appropriately to check appearance, walking around the mirror and moving the mirror, thus distracting them from their original intent of exiting. Although at times I have observed them exiting, it has proved to reduce exits significantly.

So far, we are finding the mirror only works with patients who have severe cognitive impairment (score E on the Clifton Assessment Procedure for the Elderly). Those who have moderate/marked impairment, identify it as a mirror and simply move it out of the way.

*Visual Barriers. (Namazi et al, 1989)*

The doors in my clinical area, are not a solid panel, being fire doors they have glass partition. We found that covering the whole of the glass as well as the door handles worked much better in reducing exits than just covering the door handles alone. Unfortunately, because of health & safety regulations, we had to discontinue covering the glass, but nevertheless camouflaging just the door handles is proving to reduce the number of exits.

Again, we are finding this works best with patients who have severe cognitive impairment. However, for patients who have moderate/marked impairment, we have had some success with covering the lock on the external door. They are able to work it out eventually and remove the covering, but it does reduce the number of times they would have exited.
We have had success using camouflage in patients’ homes. One 83 year old lady in particular, who lives with her son, was always exiting through the front door while her son was usually busy in the kitchen. She was able to unlock the catch, but now he has simply covered the catch with a tea towel and it has reduced her exits. In fact he reports to date, she has not exited since the covering has been in place.

We are also finding, that using both mirror and camouflage together reduces exiting considerably.

*Detour Doorkeeper (de Ganahl, 1995)*

We have placed the detour across the open doorway in the corridor where the patients’ exit from and found it significantly reduced exiting. Of the approaches monitored, patients would walk up to the detour, simply turn around and walk back onto the unit, or touch it and then turn round and walk back onto the unit.

Again, we found this only really worked well with patients who have severe cognitive impairment.

Those who have moderate/marked impairment worked it out eventually, either opening the detour, going underneath it or pushing it open.

The nursing home found it very useful. They also hope to place the detour across the open doorway of the rooms of ‘alert’ residents who have tea and coffee making facilities in their rooms, in anticipation of reducing the number of times the confused wanderer enters the room and encounter hazards.

*Structured Day (Stokes, 1988)*

Stokes believes that the provision of interest, exercise and companionship may prevent wandering occurring.

We find this works best with patients who suffer from marked/moderate cognitive impairment. However, this takes a lot of time and effort and challenges the skills and patience of the hospital/home carer. We found the wanderer, who has seemingly limitless energy, needs constant attention as they are off wandering again the minute you turn your back on them. Because they had neither the staff nor the resources, the residential home had some difficulty in structuring their patients’ day.
CASE STUDIES

Case Study One
Tom is a 57-year-old farmer who lives with his wife on an isolated farm. In 1984 he was diagnosed as having Hydatid disease. It seems that this was discovered when Tom was kicked by a horse and one of the Hydatid cysts in his liver ruptured spreading the disease through his system.

We became involved with Tom about a year and a half ago, the suspicion being that the illness had by now seriously affected his mental state. It appeared to be that the cysts had infiltrated the brain tissue, and he was now presenting signs and symptoms of pre-senile dementia, which was advancing at a rapid pace. This resulted in his admission to our unit, as his wife was finding it increasingly difficult to cope with him.

One of the major management problems Tom presented was wandering. He tends to be on the move for an abnormally large part of the time when awake, not even sitting for more than a few minutes at a time and sleeping 3-4 hours at night. We were having great difficulty in containing Tom on the unit and he had to be retrieved almost continually.

We tried structuring Tom’s day with help from the occupational therapist with daily activities. However, Tom had limited attention span and the activities didn’t keep him occupied for long.

We tried distracting his attention from wandering, talking to him about farming, helping staff with tasks and taking him for walks around the hospital grounds without much success.

As Tom tended to become angry and often refused to come back to the unit, it left us with the only option of accompanying him. This could mean spending most of the shift ourselves wandering around with him, come rain or shine.

One very wet winter’s afternoon, Tom had been out several times. He was getting increasingly agitated with us for being retrieved all the time. We decided to try the methods of deterring wandering that I had come across when researching the subject.

Firstly, we tried a mirror, (Mayer & Darby). We placed a full length mirror on a stand in front of the door which Tom exits from and monitored his approaches. A number of behaviours were observed:

On his first approach, he looked in the mirror and believed his reflection to be his father, turned away and walked back into the unit. (At this point, we wondered if this was a good idea as we didn’t want to upset Tom. Thankfully, out of all his approaches, this was the only reference to his father).

Other times, he would stand gazing into the mirror for periods of time before turning around and walking back onto the unit.
He would use the mirror appropriately and check his appearance.

He would walk around the mirror, sometimes he would even move the mirror and out of all his approaches, he exited about three times. The mirror significantly reduced his exits.

After the success we had with the mirror, we tried camouflage, (Namazi et al). We covered the door handles of the door that Tom exits from with pillowcases and monitored his approach. Unfortunately, on his first approach, he took the pillowcases off, walked around the unit with them in his hand, and on the second approach, he exited. He continued to take covers off the handles and exit with all the materials we used.

The mirror remains in use on the unit and still reduces Tom’s exits. We, as a team believe it enables him to maintain his dignity and freedom of movement, whilst at the same time, reduces time consuming monitoring and retrieval efforts by staff.

Since this case study has been written Tom has died. His wife has given verbal permission for the case study to be printed.

Case Study Two
Mrs Flower is an 84 year-old widow who lives with her bachelor son. She became known to us in 1992, having had a four year history of memory defects and gradual deterioration. On assessment, we found Mrs Flower to be a very confused lady, disorientated in time and place, but still orientated in person, and only able to respond to the most basic of instructions. She was physically fairly well for her age and very mobile. She was known to wander on occasions, easily getting lost. She was diagnosed as having Senile Dementia (Alzheimer's type). Her son felt she was not a management problem and wanted to look after her at home. So, respite care was organised on a cycle of two weeks in hospital/four weeks at home, and day care for two days per week.

Lately, Mrs Flower's wandering has become more of a problem both at home and on the unit. She tends to be on the move abnormally large amounts of the time throughout the day, only sitting for more than five minutes at a time. She occasionally wanders at night, but mostly sleeps well.

Both son and unit staff were having difficulty in containing her, and was having to be retrieved almost continually. At home she tended to exit through the front door, whilst her son was usually busy in the kitchen. Mrs Flower tended to become very angry and distressed when being retrieved, shouting for "help" and "police".

Fortunately, Mrs Flower lives in a close-knit community, neighbours know her and are happy to walk with her or take her into their homes until she is happy to go back home. On the unit, we are left with the only option of accompanying her and re-directing her back to the unit.

With her son's permission, we decided to include Mrs Flower in the project.
Firstly, we assessed Mrs Flower's cognitive and behavioural competence, using the Clifton Assessment Procedure for the Elderly, of which she scored E - severe cognitive impairment.

We then assessed the types of Wandering behaviour exhibited by her, using the Descriptive Typology of Wandering, (Hope & Fairburn), where we found that Mrs Flower's walking was directed towards an inappropriate purpose, e.g. wanting to go home, and to see her mother. Although Mrs Flower has lived at her present address for more than 25 years, and her mother had died more than 30 years ago. She did this an excessive number of times and needed to be brought back home or to the unit. She also spent some of her time pottering around, moving furniture, dusting with her dress.

When Mrs Flower came into the unit for her two weeks respite care, we tried out the methods of deterring wandering without restraint.

Firstly, we tried the structured day (Stokes). Unfortunately, Mrs Flower was not very co-operative. As she would not sit down for more than five minutes at a time, her attention span was limited and interpreting most of the approaches made to her as a threat (responded by shouting), it was agreed that this method was not suitable for her.

Next we tried the mirror (Mayer & Darby, 1991). Of the approaches monitored, this proved to be more successful. She was observed talking to her reflection, gazing into the mirror, walking around the mirror and moving the mirror. On two occasions she exited. Thus it proved to significantly reduce her exits by distracting her from her original intent of leaving the unit, without causing her any distress.

After the success with the mirror, we tried camouflaging the door handles (Namazi et al), covering them with pillowcases. The doors being fire doors with glass partitioning and very large handles proved hard to disguise and after three approaches Mrs Flower simply took the pillowcases off and exited. So we decided to cover the whole of the glass as well as the handles with a drawsheet and this worked much more effectively. Mrs Flower would walk up to the door, turn around and walk back on to the unit. The only time she exited was when a fellow patient would open the door for her.

Following the success with camouflage, we then tried the Detour Doorkeeper (de Ganahl). This was placed across the open door way of the door where Mrs Flower exits from. Of the approaches monitored, she would walk up to the detour, then turn around. On the seventh approach, she touched it then turned around. On the tenth approach, she took it down but turned around and walked back to the unit and again only exited when fellow patients opened it for her.

Of all the methods used on Mrs Flower, all proved to be successful in significantly reducing the number of times she exited the unit, hence reducing the episodes where she became angry and distressed on retrieval.
Her son uses camouflage at home. He has covered the front door latch with a tea towel and reports that Mrs Flower hasn’t exited since the tea towel has been in place.

We continue to use these methods when Mrs Flower comes in for her respite care.

**Case Study Three**

Mr Willow is 71 years old and a retired engineer, who lives with his wife, 10 years his junior. He became known to us in 1993 having had a 4 year history of gradual deterioration of short-term memory loss and disorientation out of the immediate home area.

On assessment, we found Mr Willow to be suffering from Advancing Dementia, scoring C on CAPE. (moderate cognitive impairment). He was not able to carry out simple tasks e.g. dressing himself and his long term memory was very patchy (he believes he has never married nor had children when in fact he has been married for 35 years and has 2 sons).

Physically he appears very fit, strong, young looking and very mobile. He is known to wander. He tends to head for his family home where he grew up (3 miles away) and is still able to find his way there but has to cross very busy roads to get there. Fortunately his brother still lives there. His wife states that his wandering is worse in fine weather. Usually he won't go out in bad weather.

His wife copes with his wandering by locking the front door and allowing him to wander around the house and garden, giving him simple tasks to do e.g. sweeping the garden path, but that is sometimes beyond him and he needs prompting.

His wife is still managing to keep her part-time job, with input from Social Services, family, day care for 2 days a week on the unit and, more recently, respite care in the cycle of 1 week in hospital and 4 weeks at home.

His wandering poses a considerable problem when he is on the unit. He is still capable of operating our external door lock and has proved this on a number of occasions. Luckily he has always returned to the unit when approached.

With his wife’s permission, we decided to include Mr Willow in the project.

Using the Descriptive Typology of Wandering (Hope & Fairburn), we found that Mr Willow’s wandering was directed towards an inappropriate purpose e.g. “I must go home now, my mother's waiting for me”. He would head for the family home at every opportunity (when wife/staff out of sight) and he needed to be brought back home/to the unit.

We first tried the mirror (Mayer & Derby). We placed the mirror in front of the door in the corridor, which leads to the external door that he exits from but had little success. He was still able to recognise it as a mirror and simply moved it out of the way and exited.
Next we tried the camouflage (Namazi et al). We covered the lock of the door with a piece of paper, with some success. It took five approaches to the door before he was able to work it out and remove the paper and exit.

Then we tried the Detour Doorkeeper (de Ganahl). We placed this across the open doorway of the corridor leading to the external door and again it took him five approaches before he was unable to undo the detour, walk through the doorway, replace the detour and exit.

Although the visual barriers proved not to be successful with Mr Willow, they still reduced the number of times he would have exited if they had not been in place.

Then we tried the structured day. This seems to work best with Mr Willow but it takes a lot of time and effort and also challenges the skills and patience of his carers. Fortunately he has a wide interest in gardening, listening to music, singing and woodwork. With help from the occupational therapist we were able to structure his day, working on a one-to-one basis with him. This worked really well when he was admitted for day care but when he was here for respite care it proved to be very difficult, because after 5 p.m. and at the weekends when staff numbers were depleted, the minute you would leave him to carry out nursing duties he would leave.

An alarm was attached to the external door but this only alerted us that he was leaving and it didn't deter him from going.

Now when Mr Willow comes in for his respite care we have to have an extra member of staff on duty after 5 p.m. and at weekends to continue to provide him with interest, exercise and companionship in the hope of deterring him from leaving the unit.

Case Study Four
Mrs Plant is a gentle lady of 89 years old who lives with her daughter and son-in-law.

She became known to us in 1993 having had a two year history of increasing short term memory problems, sometimes accusing her daughter of taking her belongings when she had forgotten where she had put them.

On assessment, we found Mrs Plant to be fully orientated in person, partially in time but disorientated in place, scoring C on CAPE. (moderate cognitive impairment). Physically she is remarkably fit for her age and fully mobile. She was known to wander off the unit but wandering was not a problem at home, despite being left alone for long periods during the day, because both carers are out at work.

Mrs Plant attends the unit for day care twice weekly and respite care in cycle of two weeks in hospital, eight weeks at home.

Although wandering did not present any problems for Mrs Plant and her family at home it did when she came on to the unit, as staff had constantly to retrieve her. We decided, with her daughter's permission, to include her in the project when she came in for respite care.
Using the descriptive typology of Wandering (Hope & Fairburn), we found that Mrs Plant’s wandering appears to take two main forms. One form seems to be aimless walking. She tends to walk around the hospital (but, thankfully, never out of the hospital to date) without there being any evidence of a purpose to it, and the other form is walking towards an appropriate purpose but with an inappropriate frequency (she will go to her room numerous times a day to look for her handbag or clothes because she has forgotten where she had put them). She is able to find her way to her room if we put her name on the door.

Through assessing Mrs Plant's type of wandering, we found we could distract her from wandering by structuring her day with activities such as cooking, sing-a-long, aromatherapy, memory group and even helping with chores (washing-up etc.) but not when she was looking for her handbag, etc. The only way to reassure her was to allow her to go and look for her belongings herself in her room even though she may do this every half hour because she couldn't recall previously visiting her room and putting her belongings there.

We felt that if we try to stop her from doing this by using visual barriers it would only add to her anxiety. As we know the route Mrs Plant takes, and she hasn't yet attempted to leave the hospital, we did not feel it appropriate to try the other methods of deterring wandering without restraint.

So now when Mrs Plant comes into the unit for respite care, we continue to monitor the route she takes, allowing her to keep her dignity without being retrieved by staff.

These methods are not fail-proof and do not replace careful supervision of the wanderers. We as a team believe they enable wanderers to maintain their dignity and freedom of movement. In addition these methods reduce time consuming monitoring and retrieval efforts by staff/carers.

CONCLUSION

The Project has been successful in that we have improved our current practice of the management of wandering, firstly by implementing the Descriptive Typology of Wandering (Hope & Fairburn, 1990). With the introduction of this we now able to understand more fully the variety of behaviours observed during wandering and have a more systematic method of assessing wandering behaviour. As a result we are able to plan care more effectively.

Secondly, we have successfully tested out and found effective methods of reducing the incidence of wandering, without using restraint and at the same time maintaining the patients' dignity and their to move around freely.

Lastly and importantly, we have been able to incorporate these techniques into a booklet for carers so they too can understand more about Wandering and its management.
REFERENCES


APPENDIX 1

QUESTIONNAIRE TO DETERMINE THE TYPE OF
WANDERING IN DEMENTIA PATIENTS

Wandering in the cases of elderly people suffering with dementia is, sadly, a fairly common problem and it is often a problem which causes great difficulties to the carers and to ward staff who are attempting to look after the elderly person.

We would therefore be grateful if, as a part of an initial research exercise into the problem of wandering in dementia, you would complete the following brief questionnaire.

The information could be obtained from the patient's domestic carers, from the community psychiatric nurses or following your observations of the patient on the ward. It's then simply a question of ticking the box (or boxes) which you think most appropriately describes the nature of the patient's wandering.

Thank you for your help.

PATIENT'S NAME

SEX M/F

DATE OF BIRTH

PRESENT AGE

IS THE PROBLEM THOUGHT TO BE DEMENTIA? YES/NO

IS THERE A PROBLEM WITH WANDERING? YES/NO

IS IT POSSIBLE TO ROUGHLY PUT A DATE TO THE START OF THE PROBLEM OF WANDERING? YES/NO

IF SO, WHEN DID IT START?

Questionnaire Completed By:

Date:
WANDERING IN DEMENTIA CONT.

Example:

How would you describe the nature of the patient’s wandering?

It may be that you feel that you should tick more than one box. E.g. both Aimless Wandering and Night-time Wandering

<table>
<thead>
<tr>
<th>TYPE OF WANDERING</th>
<th>TICK BOX</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CHECKING / TRAILING</td>
<td></td>
</tr>
<tr>
<td>In ‘Checking’, the subject repeatedly seeks the whereabouts of the carer or another person. ‘Trailing’ appears to be an extreme form of checking in which the subject tends to follow the carer or another person around excessively, e.g. walking closely behind them.</td>
<td></td>
</tr>
<tr>
<td>2. POTTERING</td>
<td></td>
</tr>
<tr>
<td>The subject walks around the house, garden and/or ward apparently trying, but ineffectively, to carry out tasks (e.g. washing or drying up, cleaning, weeding) of his or her own accord.</td>
<td></td>
</tr>
<tr>
<td>3. AIMLESS WALKING</td>
<td></td>
</tr>
<tr>
<td>The subject walks around - inside or outside - without there being any evidence of a purpose. This category should not be used if there appears to be a purpose, however bizarre, if the wandering meets the criteria for either Checking/Trailing or Pottering.</td>
<td></td>
</tr>
<tr>
<td>4. WALKING DIRECTED TOWARDS AN INAPPROPRIATE PURPOSE</td>
<td></td>
</tr>
<tr>
<td>The subject’s walking seems to be directed towards a purpose but the purpose is inappropriate (e.g. searching for a deceased relative). If the purpose is inappropriate only because of excessive repetition, rate this in Section 5 below.</td>
<td></td>
</tr>
<tr>
<td>5. WALKING TOWARDS AN APPROPRIATE PURPOSE BUT WITH AN INAPPROPRIATE FREQUENCY</td>
<td></td>
</tr>
<tr>
<td>The walking is directed towards some appropriate purpose (e.g. shopping) but is repeated with in appropriate frequency (e.g. wants to go to the greengrocers’ six times a day).</td>
<td></td>
</tr>
</tbody>
</table>
6. EXCESSIVE ACTIVITY
The subject is on the move for an abnormally large part of the time whilst awake, perhaps not sitting for more than a few minutes at any time. Subjects who rate here will normally also rate under one of the preceding categories.

7. NIGHT-TIME WALKING
The subject walks around inappropriately during the night. This category would not be used if the subject gets up only to go to the toilet.

8. NEEDS TO BE BROUGHT BACK HOME OR BACK TO THE WARD
The subject needs to have been brought back to the place of residence on at least one occasion, perhaps he/she could not find the way back alone. Often, it is not possible to know for definite whether the subject could have got back unaided if left alone.

9. ATTEMPTS TO LEAVE HOME OR THE WARD
Attempts have been made to leave his/her place of residence, but these are prevented by others. This category is included to rate wanderers who might have fitted into categories were it not that their movements have been restricted by concerned carers.

PLEASE FEEL FREE TO ADD ANY OTHER COMMENTS ABOUT THE WANDERING THAT YOU FEEL WOULD BE USEFUL:

Thanks for your help.

R.A. Hope, G.G. Fairburn, University Department of Psychiatry, Warneford Hospital, Oxford.
APPENDIX II

The following report forms that make up Appendix II can not be re-produced here for copyright and technical reasons.

1. Clifton Assessment Procedures for the Elderly (Cape) - Cognitive Assessment Scale.
(The published edition of this report form is printed in coloured ink.)

2. Clifton Assessment Procedures for the Elderly (Cape) - Behaviour Rating Scale.

3. CAS Reading List

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4. The Gibson Spiral Maze

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