# Wandering

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## Introduction

Wandering has become one of the behavioral characteristics included in the descriptions of persons with Alzheimer's disease. The behavior may present insurmountable problems for family caregivers and create a serious dilemma for nursing home staff who are responsible for the care and safety of their residents. Solutions are difficult with caregivers facing the issue of how to provide protection without stripping the individual of freedom of movement.

The dictionary defines the term "to wander" as "to ramble without any certain course or object in view; to roam, rove, or stray; to go aimlessly or casually; to take one direction or another without intention or control." In this article, wandering[7] refers to ambulation that is self-initiated and occurs independently of environmental cues such as the ringing of a bell for meal time, or an invitation by staff to take part in an activity.

The wanderer who is in the early or middle stages of Alzheimer's disease is a fully conscious and alert person who, if well cared for, is often in good physical health. His energy level may be very high and coupled with his desire to maintain control over his own life, may result in vigorous efforts to resume his earlier life style. At the same time, the individual is experiencing a loss of normal intellectual functioning, and cognitively is seriously

impaired, causing him to have difficulty with memory and learning. He has poor judgement, spatial disorientation and an inability to think abstractly.

The typical person with dementia lived for 65 or more years during which time habits have been formed and become deeply ingrained. These habits remain sufficiently intact that, as in the past, they motivate the individual to repeat them even though he can no longer use them rationally or intelligently.

***. . . the human being is an energy machine that generates large amounts of energy required to activate the body.***

The wanderer might be described as an individual with a supply of unused energy, who is physically fit, who responds to well established patterns of action, and who sets out to achieve a goal — of going home or to work, for example. He may remember his earlier home or his place of work quite vividly, but he no longer can recall his present location or the route to his destination. He does not realize that he is spatially disoriented, so he sets out, may soon forget his goal, become frightened and agitated, and wander on and on. It is a tragic parallel to the stories told of persons lost in a forest who find themselves going in circles with no hope of escape.

The above example describes wandering that results from excess energy and lifelong habits, but the literature has suggested many other possible causes for wandering behaviors.[1,2,3,4,5,] For some individuals wandering may release some of the tension resulting from stress. Persons in nursing homes or other facilities may find that living with a large number of strangers is overwhelming and intolerable. Wandering may be an attempt to escape from crowds or noise or from what may seem like a strange and unfriendly environment. It often seems to be the impaired person's efforts to locate something to handle or touch. Wandering behaviors are, at times, evidence of disorientation as with the person who paces back and forth in a hallway attempting to locate the bathroom or her own room. For some, the activity may have been job related, as with farmers or postmen, and walking may represent a way of recapturing familiar routines.

Boredom is one of the causes of wandering behavior frequently mentioned by researchers.[2,4,6] Wandering from boredom can occur when there are few or no opportunities for resident involvement, no sensory stimulation, nothing to help residents have a sense of belonging and being needed, and no meaningful use of time. The self-initiated activity that results frequently takes the form of restless wandering or the repeated handling of objects.

This article presents the point of view that much of the wandering that occurs in treatment settings may be the result of nontherapeutic environmental factors that could be altered in order to reduce the impaired person's need to wander.[6] In the nontherapeutic setting many of the behaviors of those with dementia are interpreted as abnormal and requiring interventions that force a change in behaviors.

In the therapeutic setting staff are trained to be accepting and to recognize that some of the behaviors of the person with Alzheimer's disease are normal responses to the environment. It becomes the responsibility of staff to examine the events and conditions which might be causing the impaired person to become agitated or angry and make essential adjustments to reduce the stress or irritations that may be triggering the behavior.

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The urge to move about and explore is a part of the personalities of many people. Whatever the specific reasons may be for wandering behavior, the staff in treatment settings are faced with the difficult challenge of making available to residents safe and interesting areas to walk, at the same time, providing an exciting, stimulating, and satisfying milieu that will reduce the person's need to wander.

### In search of safety

A variety of interventions are being tested in nursing homes and special Alzheimer's units to provide safety and protection for those who wander. In unlocked units, chimes are

sometimes attached to doors so they will ring when doors are opened. There are also systems available which use electronically coded tags installed in bracelets or necklaces worn by residents to trigger an alarm when doors are opened. When this system is in use, it is important that the alarm be pleasant and subdued rather than an offensive sounding buzzer which can frighten residents and cause them to become agitated. Special door knobs can now be purchased from hardware stores that are exit proof except by special manipulation. So locked units where staff are reluctant to use a key for locking and unlocking doors, have installed a mechanism that operates by means of pressing buttons in coded sequence. Other units have found that a full-length mirror on the door is a deterrent for many residents. Sometimes painting doors the same color as surrounding walls serves as a sufficient camouflage to prevent persons from wandering from the area.[8]

Physical restraints and over-medication are all too frequently seen as the only solutions to the wandering problem. Currently there is much evidence to suggest that physical restraints cause agitation and do not serve as protection against falls.[9,10,11] These studies indicate that restraints should be used as a last resort and then only for limited periods of time. The use of restraints is one of the most degrading and humiliating interventions currently used in our health care system. Over-medication is also damaging. In some instances it causes a disintegration of the personality of the elderly individual and prevents a response to the environment or to other people. Some persons may react to medication in ways that cause them to become more agitated and disturbed.[12]

There is a need for safe walking areas both indoors and outside of facilities, and as part of their building plans, many special units are now including walking corridors. However, there are a number of issues related to these designs that need to be examined. "Race track" is becoming a common term to describe the circular corridors that are being built in some newly designed settings. It may seem unimportant and trivial, but to this author, the term "race track" is offensive. Putting people on a "race track" to take care of their need for physical activity is not far removed from placing animals in dog runs. It is the implication of the term that is disturbing. There is another issue to be considered also. The "race track" may be a cost saving measure, because it frees staff time when persons are on the track, but it is important that the availability of such space is not viewed by staff as sufficient intervention to satisfy the needs of persons with dementia. It may provide safe walking space, but that is only one of the essentials in offering persons with dementia satisfying and meaningful lives. The latter part of this paper will present the point of view that the creation of a rich and supportive environment, while it will not eliminate, will greatly reduce wandering behaviors.

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### The impact of a rich and accepting environment on wandering behaviors

A rich, stimulating, and accepting environment in a residential care setting for persons with dementia can provide a quality of life that will reduce many of the "difficult" behaviors identified with Alzheimer's disease; including wandering. A setting that offers a variety of opportunities from which residents may choose, can provide companionship and reduce loneliness. Lighthearted, engaging and stimulating activities can divert residents from the things that cause them to become anxious and apprehensive; and their self-esteem can be improved by helping them to continue to perform everyday tasks to the fullest extent possible.[13,14,15,16]

*Need for a settling-in period.* Nursing home staff who are responsible for establishing special units for persons with Alzheimer's disease or other dementias will need to be prepared for what Burnside[17] calls a "settling-in" period. In the early months after a unit is opened, both residents and staff may experience a great amount of stress as they attempt to cope with both an unfamiliar setting and strange people. Residents will need special support and reassurance during this early period when staff, themselves, are attempting to find solutions. It is often during the first several months that

residents most frequently leave an unlocked unit. This is frightening for staff, but especially for a wandering resident who becomes lost in unfamiliar surroundings.

A number of precautions can be taken for several months until an area becomes stabilized. Staff can become especially alert to sounds of residents moving about. If they are sharing an activity with a wakeful resident in the middle of the night, they can sit in an area where they have easy visibility to residents' rooms. For a short period of time a wall hanging can be placed over the elevator buttons to serve as a deterrent.

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*Night wandering.* When a special unit is established, staff on the night shift need to be prepared for much involvement with residents. Interventions can include a variety of activities that can help residents relax. It is unwise to try to forcibly stop a person who is wandering. Instead a staff person can walk with her and gently distract her by drawing her attention to something else. They can have a snack together, prepare muffins or cookies, or watch television. At other times helping the person back to bed, rubbing her back, and chatting briefly is enough to help her relax. It is important that the staff person decrease, not increase, stress, making it obvious that wandering or night restlessness is acceptable. If staff are supportive, most of the residents will become comfortable and relaxed, and night wandering will become greatly reduced.

*Evening restlessness.* At times, residents are especially restless after the evening meal. Their agitation frequently affects others and can produce group turmoil that leads to restless pacing. Some of the most effective interventions are spontaneous and lighthearted activities that are fun and relaxing. Exercising, ball tossing, and singing all help to lighten moods and distract residents. Sharing in the preparation of snacks can be especially popular. Even those who are not actually involved in the preparations can be active observers and share in sampling the finished products. This involvement not only reduces the evening restlessness, it also can help to lessen night wandering, because residents go to bed relaxed and tired.

The case descriptions presented here were part of a special two-year demonstration project by the Institute of Gerontology, The University of Michigan in cooperation with the Chelsea United Methodist Retirement Home, Chelsea, Michigan. The special unit was called Wesley Hall.

*Reactions to crowds or noise.* Mr. E seemed to enjoy the various activities offered, but at times when there was much conversation and laughter, he became agitated and attempted to leave the group. He would jump up from his chair, swear and shout, and leave the room to begin pacing through the hallway. Staff found that by going to him when they sensed that he was becoming disturbed, and suggesting gently that they walk a while and then have refreshments together, he quickly relaxed and seemed to forget the cause of his frustration. At times, several women became quite agitated when they heard the intercom speaker in the hallway. They looked around and began wandering frantically in an effort to locate the person speaking. This disturbance was easily eliminated by disconnecting the intercom speaker.

*Searching for someone.* In the evening Mrs. R frequently wandered from her room to the living room, to the kitchen, and down the hallway in search of her deceased husband. This pattern continued over a period of time as she became increasingly agitated. When approached by staff, she usually responded angrily saying her husband should have been there hours ago to take her home. Several interventions were tested over a period of time. While no single approach was consistently successful, having a number from which to choose helped staff reduce Mrs. R's agitation and wandering. Mrs. R was easily diverted, and staff found that she would often forget her search for her husband if they talked about a recent visit of a member of her family. At other times she would respond to a group activity when staff called to her and said, "We need you for our ball game." She could seldom resist when the ball was tossed lightly to her.

Gradually, as staff became more sensitive to her moods, they found that these diversions helped her to relax and forget what had earlier caused her so much stress.

Mrs. M would occasionally become agitated and would wander through the area in search of her son. Staff found that she usually responded to their reassurance that her son had been to visit her recently, that he would be coming back in a day or two, and that he was at home with his family at the moment. Staff would sometimes walk with her to her room and point out pictures of her son and his family and discuss what they had done together on his last visit.[18]

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*Boredom.* A dull, uninteresting, and unstimulating environment will inevitably lead to behaviors that reflect the individuals' feelings of anger and frustration or hopelessness, discouragement, and depression. During the first month or two after a special unit opens, staff are so preoccupied with the daily routines that they are unable to manage the many activities involving residents that later can become very much a part of the life of a unit. Even though most of the residents are unable to verbalize their frustrations with their boring existence, they can express it in other ways.

Mrs. O and Mrs G paced constantly from one end of the hall to the other, sometimes alone, sometimes together muttering angrily to each other. When a settee was placed in the living room in a location giving occupants a view of all of the action in the kitchen and the hallway, they adopted the space as their own. With this accidental solution, they seemed entertained and more relaxed in their new role as "people watchers."

***Interventions can include a variety of activities that can help residents relax.***

Mr. B at times wandered from room to room in search of staff. When he located a staff person, he would express his frustrations by saying again and again, "What's to do? What's to do?" Gradually staff learned to involve him in a variety of tasks. He would usually respond to such invitations as "Will you help me push the food cart to the elevator?" or "Will you go down stairs with me to pick up the newspaper?" or "Will you help me set the tables?"

*Disorientation.* Much of the wandering back and forth in the first several months of the opening of a unit may result from the efforts of residents to find the bathrooms or their private rooms. Staff can help a resident simply by saying "Let's walk down to the bathroom together" or "Let's go to your room and I'll help you get dressed." Signs reading "Men's Bathroom" and "Women's Bathroom" attached to the doors can help those who are still able to read. Different colored awnings fastened above the men's and women's bathroom can serve as effective location symbols for those who can remember their purpose. To help residents locate their own rooms, a wooden plaque containing name and a personal photograph can be attached on the wall next to each door. In addition, a decoration can be fastened to each door which symbolizes the resident's past interests or vocation. Signs with arrows can be placed in the hallway to point the direction to the living room, kitchen, and dining room. These are not helpful to everyone, but they can assist those who can still read and interpret the words.

***It is unwise to try to forcibly stop a person who is wandering.***

*Searching for something to handle.* Occasionally, wandering activities seem to be a search for something to touch and handle. For example, some persons may manipulate door knobs repeatedly without making efforts to leave the area. This need was satisfied by one wife who brought a box for her husband filled with a variety of his possessions. He handled them frequently and seemed to get reassurance and comfort from them.[15]

*Need for exercise* For many persons with dementia, walking may satisfy a need for exercise and movement that parallels that of their earlier lives. Staff can respond to this need

by making safe walking space available and by walking with residents both indoors and outdoors. Exercise programs and yoga classes are also helpful and can serve to lighten moods and encourage interaction.[19]

## Conclusion

Wandering, like many other behaviors attributed to those with dementia, needs to be considered from the point of view of the impaired person. The issue then becomes one of attempting to determine why a behavior is occurring and if the behavior itself in some way gives relief and help to the individual. If staff can become sensitive to the needs of persons with dementia and aware of the impact of a hostile environment, they will recognize that many of the so-called difficult behaviors are far more normal than those enforced by some treatment settings. It is normal to want to walk and move about at will. It is neither normal nor healthful to sit in a chair from morning till night because one is confined by physical restraints. It is normal to become angry in an environment that is unsympathetic and uncaring. It is neither normal nor healthful to lose one's ability to react to one's surroundings because of heavy dosages of medications.

Caring for persons with dementia is a difficult task. There are no ready formulas to solve the constantly changing problems that arise daily in caring for this challenging group of people. Staff can be trained to create special units for persons with dementia that give residents a sense of ownership, of being needed and wanted, and of having close and warm relationships with staff and other residents. For imaginative and creative staff persons who are able to build on the remaining abilities and personality of each individual with Alzheimer's disease or other dementias, the work can be exciting and rewarding.

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