

# Keeping Dementia Residents Safe

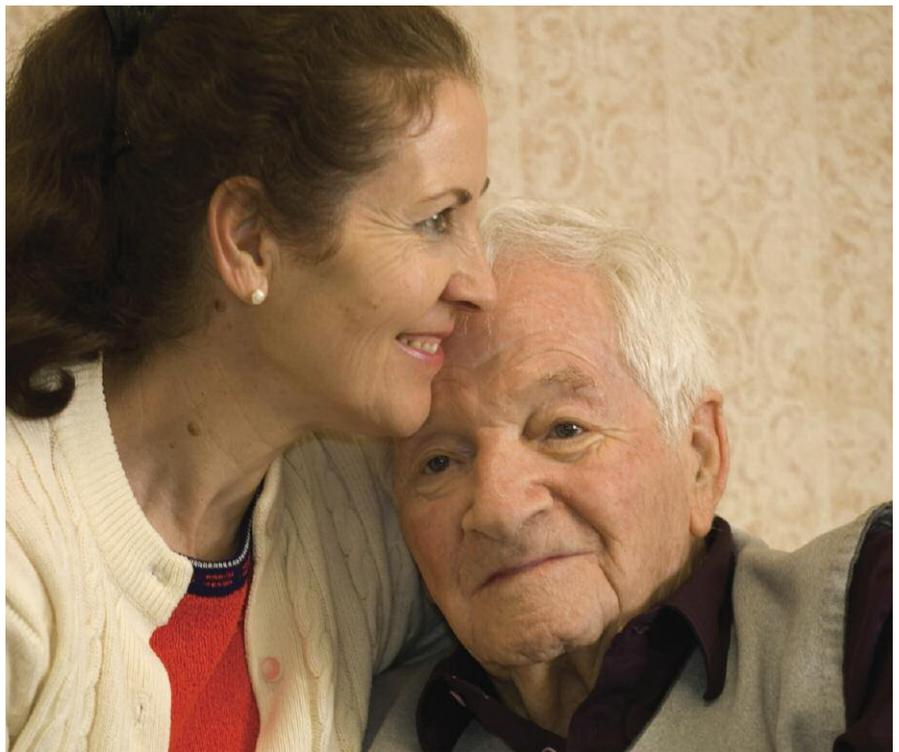
Anne Ellett, NP, MSN

**A**ssisted living (AL) operators face many challenges when it comes to providing good care to residents with cognitive impairment. Unsafe events in their own homes, such as falls, injuries, medication mismanagement, and episodes of wandering, are often the precipitating factors that motivate a family to recommend that their loved one move to an AL environment.

In one recent survey, it was reported that 33.3% of AL properties are licensed for dementia care. Even in those AL properties not licensed for dementia care, there are many residents with some degree of cognitive impairment requiring extra monitoring and assistance with activities of daily living (ADLs). The typical AL resident needs assistance with 2.25 ADLs (bathing, dressing, transferring, toileting, and eating). The average age of AL residents is 85.3 years old<sup>1</sup> and with age comes increasing risk of cognitive impairment. Nearly 1 out of 2 people older than 85 has Alzheimer's or other form of dementia.<sup>2</sup>

Residents with cognitive impairment have special safety concerns. They are especially vulnerable because they may not be able to articulate their needs. In particular, there are 4 specific areas of safety concern for those dementia residents living in an AL setting:

- Risk for wandering and elopement
- Falls and injuries
- Challenging behaviors
- Polypharmacy



One-on-one caregiver Lucy Czakowska and resident Ernie Fybel share a quiet moment at Silverado, Encinitas.

*Photo courtesy of Silverado Senior Living.*

## Wandering and Elopement

Wandering and elopement is every AL operator's nightmare situation. This behavior is common in people with dementia, and the Alzheimer's Association reports that more than 60% of people with Alzheimer's disease wander at some point. Therefore, there is a high probability that many residents living in your AL community are at risk for wandering and elopement. And many residents wander repeatedly.

Wandering is not just aimless movement. *Wandering* is defined as purposeful behavior initiated

by a cognitively impaired and disoriented individual characterized by excessive ambulation, leading to safety and/or nuisance-related concerns.<sup>3</sup> Even though residents may have dementia, their behavior can be very purposeful. Dementia residents often have a goal in mind (to return home, find their children, go to their former work site) and search over and over again for a way to get to their destination.

An example is a resident who was living in a dementia-specialty AL facility and eloped 2 times.

Each time he had the same goal—to get to city hall to obtain a marriage license for him and his favorite female staff person to get married. By closely following a visitor out of the security-coded front door, he was able to get several miles away. He kept asking for directions from passersby and eventually did arrive at the local city hall. An astute clerk there noticed his general level of confusion and some printed literature in his coat pocket. Luckily it was a brochure of his AL community. Phone calls were made, and he was safely returned. This AL community learned that even a very confused person can, if he or she focuses on a goal, often successfully figure out a way to elope, even from a secured environment.

If a resident is successful in elopement and is injured, expensive liability claims may follow. Common allegations in these suits include failure:

- To hire sufficient staff to adequately supervise residents
- To train professional staff to properly supervise residents
- To employ alarms or other devices to prevent elopement
- Of staff members to properly respond to alarms

Development of a policy and procedure for assessment of elopement risk and an emergency “missing resident” plan can help minimize the risk for elopement and injury.

The greatest risk period for resident elopement is often in the initial transition to the AL. In the new environment the resident may be anxious, mistrust staff, and explore all areas of the AL for an opportunity to elope.

### **Resident Assessment for Elopement Risk**

Directly ask the family if there have been any episodes of wandering and elopement prior to admission to help identify high-risk residents. Often families are hesitant to mention that

there have been previous episodes because they fear the facility won't allow their loved one to move in.

Map the resident's behavior for an initial period (3 to 14 days are recommended) to provide detailed information about the new resident's activities and any triggers for elopement-seeking behavior.

Training of associates is constant and ongoing. Train staff how to respond to door alarms, and make sure they know which residents are at risk for elopement. Educate staff about how to redirect residents away from the exits and engage them in desirable activities. Make sure staff regularly check on high-risk residents to determine their whereabouts. Ensure that photo IDs

**Even a very confused person can, if he or she focuses on a goal, often successfully figure out a way to elope.**

of all residents are available, assign designated search areas to individual staff members, determine a timeframe in which the administrator and family are to be contacted and when the local police are to be notified, and conduct drills on a regular basis with all shifts.

Also ensure that all exits are clearly in view and alarms and cameras are in place. Post staff in view of all exit areas.

### **Fall and Injury Prevention**

Risk of falls and injuries is another area of safety concern for all elderly adults, but especially so for residents with dementia. Falls are the most frequent cause of injury in older adults. Thirty-three percent of adults ages 65 and older fall each

year, and of those who fall, 20% to 30% suffer moderate to severe injuries.<sup>4</sup> There aren't any published reports of the frequency of falls in AL, but one study of continuing care retirement communities indicated a fall rate of 56% annually.<sup>5,6</sup>

The average age of residents in AL facilities is 85.3 years old,<sup>1</sup> so it is no surprise that falls and injuries are a frequent occurrence. Dementia residents are at increased risk of falls because of their judgment impairment and often other accompanying risk factors such as altered gait and sensory deficits.

The greatest predictor of a fall is a previous fall. If the AL staff obtains information from the family that there is a history of previous falls, they can identify that resident as high risk. Some other risk factors to consider are:

- Lower extremity weakness
- Gait disorders and decreased range of motion (ROM)
- Inability to transfer to a chair without assistance
- Associated medical conditions, such as cardiac impairment or Parkinson's disease
- Polypharmacy
- Use of psychotropic medications
- Visual impairment
- Incontinence

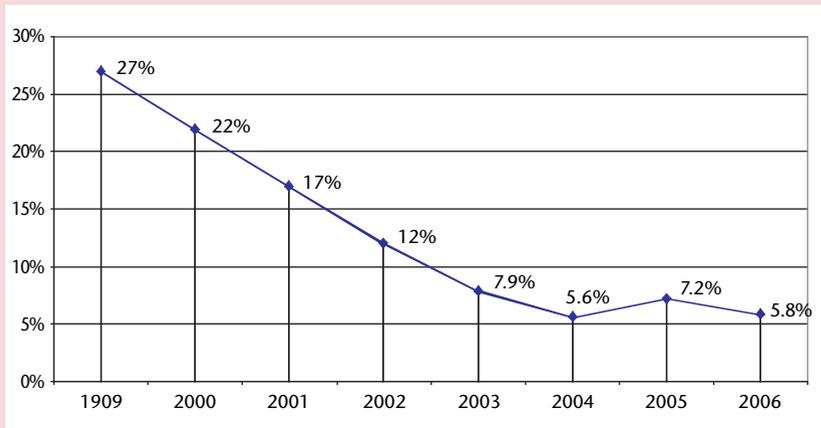
The challenge for AL facilities is keeping dementia residents safe from injuries but allowing them the dignity of choice in an environment that is as unrestrictive as possible. These goals may seem contradictory. Is maximizing independence and choice inconsistent with preventing falls and fractures?

At Silverado Senior Living, we have been very successful in keeping fall and fracture rates low through a focused fall and injury prevention program (Figures 1 and 2).

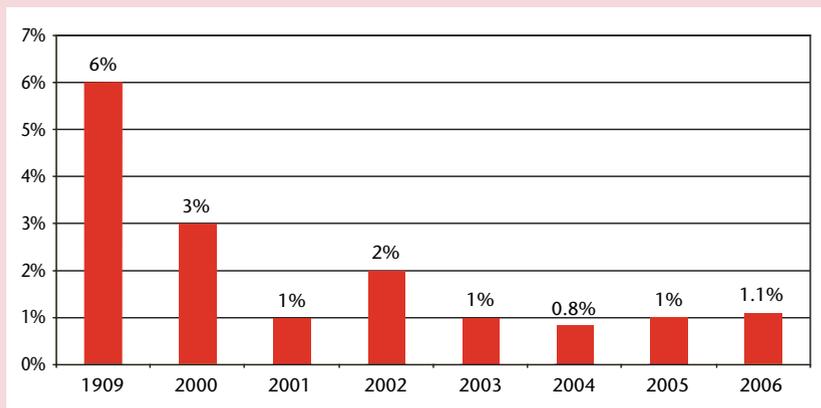
Because the cause of most falls is multifactorial, Silverado Senior Living includes several key components in their fall and injury prevention program:

- Universal precautions: ALL resi-

**Figure 1.**  
Injury rate from falls at Silverado Senior Living



**Figure 2.**  
Fracture rate at Silverado Senior Living



dents are viewed as high-risk fall candidates because of their dementia

- Extensive and on-going training of all staff (including culinary, housekeeping, activities, and leadership staff) regarding risk factors for falls and which residents were at highest risk
- Scrutiny of the environment for any factors that may contribute to resident falls
- Increased use of physical therapy and restorative care to improve gait and increase transfer skills
- Daily exercise programs for residents to keep them active and

prevent deconditioning (Figures 3 and 4)

- Use of hipsaver garments by most high-risk residents
- Regular review of medications to avoid sedation or other drug-related adverse effects that can contribute to falls
- Review of every fall to determine contributory factors

### **Polypharmacy**

By definition, *polypharmacy* means many drugs. Elderly adults use more drugs because illness is more common in older persons. Polypharmacy leads to greater risks of adverse drug reactions

(ADRs) that are directly related to the numbers of medications taken. The risk of ADRs rises exponentially as the number of drugs increases (Figure 5).

A person's ability to absorb and metabolize numerous medication decreases with age. A recent study showed that the average number of medications taken by an AL resident is 8.7.<sup>1</sup> Residents with dementia often take many more than the more independent residents and are unable to tell staff if they are feeling poorly from the medications. Excessive medications that can contribute to the risk of falls, such as psychotropic medications, sleeping medications, and sedatives, are sometimes given to help staff deal with difficult behaviors such as yelling, wandering, aggression, or other antisocial behaviors in dementia residents. Antihypertensive agents and other cardiac medications may also cause changes in pulse and blood pressure and symptoms such as light-headedness or dizziness. Because dementia residents are especially vulnerable to polypharmacy, it is helpful to have nursing or other trained staff review all medications on a regular basis and work with the family and physicians to appropriately reduce and discontinue medications no longer beneficial.

Altercations between residents or between staff and residents can lead to injuries. Managing these behaviors can be very difficult for the staff. However, before any such medications are added, it is helpful for the staff to "behavior map" the resident to determine what might be triggering these challenging behaviors. Behavior mapping notes where the resident is and what the resident is doing every 15 to 30 minutes for 24 to 72 hours. Often a pattern of behavior can be discovered. For example, aggressive behavior may show up more often late in the day when fatigue or sun-downing is a factor. The resident's

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creasingly significant part of my practice. Typically I spend 1 or 2 days a week providing scheduled visits to off-site patients.

An underappreciated aspect of these off-site visits is the support I get from my staff members back at the clinic. This type of care often generates paperwork for Medicare and Medicaid reimbursement, and I am blessed with skilled workers at my Mobile Care Hearing clinics.

They who process these tasks perform a yeoman's service for the patient, the family members, and me. Off-site care takes a team approach, and scheduling and billing are important functions to providing necessary and timely care.

Working with these off-site patients is personally and professionally very rewarding for me. It is wonderful to make a follow-up visit to a SNF or AL facility and see the smiling patient in the activities room playing cards with friends rather than hiding in a bedroom. It is rewarding to know that the patient is getting better care and improving medically because he or she can better communicate with doctors, dentists, staff

**Most people will live with a hearing loss for 7 years before receiving an initial exam because they are in denial.**

members, and other caregivers.

Facilities that focus on providing care to help residents remain healthy and independent require contributions from many healthcare disciplines, including physicians, pharmacists, nurses, dentists, chaplains, physical and occupational therapists, social workers, and, yes, even audiologists. ALC

**Dr. William Grimm, a board-certified audiologist, has been in practice for 27 years. Since 1992 he has directed the clinic now operated by Mobile Care Hearing in Lima, Ohio, and is now Vice President and Director of Audiology for Mobile Care Hearing, Inc. Mobile Care Hearing allows its customers to save time and money through high-quality testing by a professional audiologist performed at SNFs or AL centers. Mobile Care Group, Inc. (MCG) also offers vision, dentistry, podiatry, psychiatry, and optometry care services. Not only will they coordinate monthly on-site health care to senior communities, but they will also manage the entire process of billing Medicare, Medicaid, and private insurers. For more information, visit [www.mobilecaregroup.com](http://www.mobilecaregroup.com).**

### Keeping Dementia Residents Safe

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ability to cope with another resident or cooperate with staff may be diminished. Also, sudden changes in behavior may be the only sign

that a dementia resident has an acute medical condition, such as a urinary tract infection.

Keeping dementia residents safe

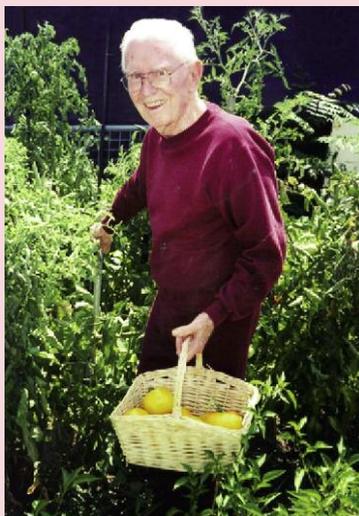
in AL can successfully be accomplished and provide an environment that offers freedom and dignity to these special residents. ALC

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**Figure 3.**  
Silverado residents participate in yoga classes.



**Figure 4.**  
A Silverado resident works in the garden.



### References

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