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STANDARDIZED CARE PLAN: Managing Alzheimer's Patients at Home

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Abstract

Alzheimer's disease and related disorders (ADRD) are chronic, common, costly, serious, and increasing health problems that affect about 3% of persons between the ages of 65–75; 18% of persons between the ages of 75–84; and 47% of those over age 85, or over 4 million Americans (Evans, 1989). Sixty percent of all dementias are reported to be of the Alzheimer's type (Pajik, 1984). The course of the disease, while one of inexorable deterioration, is unpredictable, ranging anywhere from 1 to 20 years from diagnosis to death (average 8 to 10 years).

Early clinical manifestations include short-term memory impairment; sensory changes; losses in judgment, abstraction and logic; difficulties with reading comprehension; decreased socialization; subtle personality withdrawal; and losses of instrumental activities of daily living, such as driving, cleaning, and the ability to cook, manage money, or sustain a household.

Disease progression is most often accompanied by greater deficits in memory, language losses, and the progressive decline in self-care abilities, which leads to greater dependence on others (usually family members) for assistance with functional needs and emotional

support. This reliance on others is complicated by disease-related personality alterations, which may enhance negative personality characteristics and cause the patient to become rigidly inflexible, reject changes in routine, lose the ability to express gratitude, and, in many cases, reject assistance from people other than the primary caregiver. Thus, it is not uncommon in the middle to late stages of the disease to find that the patient with ADRD becomes fearful of having the primary caregiver leave his/her sight, not even to allow privacy in the bathroom. In this situation, caregiving becomes a 24-hour-a-day job, complicated by the development of secondary episodic behavioral symptoms (discussed below), causing the patient with ADRD to become agitated, increasingly disoriented, and/or panicky.

Persons with dementia present many difficult care problems because of their progressive cognitive and physical deterioration. The severe cognitive changes so characteristic of dementia-causing illness are frequently accompanied by equally disturbing dysfunction in behavior or secondary symptoms. Between 70% and 90% of all persons with dementia-causing illness experience some form of these symptoms, often on a daily basis (Teri, 1989). A number of investigators have concluded that the symptoms of persons with dementia-causing illness that are most problematic for their caregivers are: agitation; waking at night confused and upset; the inability to recognize their home and/or caregiver; belligerent and angry outbursts; attempts to wander; hallucinations and delusions; combative episodes; incontinence; suspiciousness; and poor communication (Chenoweth, 1986; Gmeiner, 1987; Rabins, 1982). Other reported troublesome behaviors include: repetitive questions; wandering; embarrassing, dangerous and hostile behaviors; and difficulty with bathing and other instrumental activities of daily living (Grunow, 1987; Quayhagen, 1988).

When caregivers lack the behavioral skills to manage these secondary symptoms effectively, as well as more routine care problems, the disturbing behaviors often escalate, leading to increased confusion, agitation, and a “downward spiral” of impairment (Cohen-Mansfield, 1986). Behavioral problems and caregiver stress or illness constitute primary reasons for institutionalizing persons with ADRD (Ferris, 1987; Ryden, 1988; Zarit, 1986).

Nevertheless, somewhere between one half to two thirds of patients suffering from dementia-causing illnesses live at home (Rabins, 1984), and this trend is expected to continue because of projected cutbacks in services such as respite for this population. As the percentage of older Americans increases (from 11.3% in 1980 to a projected 21.6% by the year 2040), the number of cases of dementia-causing illnesses is expected to quintuple (Office of Technological Assessment, 1987). Due to the chronic, debilitating nature of this disease, it is estimated that at least 15 million additional family members also are affected (Cohen, 1986). Direct costs to society are estimated to be \$38 billion annually, and total costs, which include indirect expenditures, exceed \$88 billion every year. Impaired elderly are often placed in long-term care facilities (LTCFS) when family caregivers are either no longer available or are unable to continue home caregiving (Colerick, 1986).

The provision of in-home care costs an estimated \$13 billion annually compared to an estimated \$41 billion for nursing home costs (Young, 1990). These monetary estimates in no way reflect the human costs of this devastating disease, which represents an escalating

health care problem that currently cannot be prevented nor its course reversed (Advisory Panel on Alzheimer's Disease, 1989).

In light of the emotional trauma and expense associated with placement for both the ADRD victim and family, interventions that help family caregivers to prevent and/or manage behavioral symptoms, and perhaps delay institutionalization, are timely and significant (Figure 1).

FAMILY CAREGIVER STRESS

Caregivers of ADRD patients often experience significant emotional stress and extreme physical and financial burdens, in addition to apathy or hostility from the care recipient. Thus, caregivers may become “hidden patients” themselves, needing outside assistance and support to maintain their own health and functioning (National Institute on Aging, 1992). A number of converging trends suggest that demands on family caregivers will only continue. These trends include: increased longevity, geographic dispersion of the family, the need for many caregivers (especially women) to enter the work force, and changing patterns of marriage and child care (Advisory Panel on Alzheimer's Disease, 1989). Thus, there is an ever-increasing number of “old-old” who require care from adult children and spouses, who themselves may be elderly and infirm. The increasing mobility of our society also diminishes access to family care. Increases in maternal age at the time of the birth of the first child means that more caregivers are experiencing “double dependency” caring for a parent and a child simultaneously, causing a phenomenon Brody (1985) has labeled “the Sandwich Generation.”

Although caring for a relative with dementia-causing illness is among the most difficult forms of family responsibility, caretakers often receive inadequate support and training for the task. Thus, they may become physically and emotionally exhausted, and/or face social deprivation and financial ruin (Buckwalter, in press). These caregivers identify multiple demands placed upon them, which culminate in increasing levels of stress (Bailie, 1988; Cohen, 1986; Given, 1988; Haley, 1987; Scott, 1986). Negative caregiver outcomes are most prominent in the areas of mental health and social impairment (Archbold, 1986; George, 1986; Haley, 1987; Zarit, 1980). Of particular note is the large number of methodologically rigorous studies citing caregiver depression as a major residual (Barusch, 1988; Cohen, 1988; Coppel, 1985; Eisdorfer, 1983; Fiore, 1983; Gallagher, 1989; Goldman 1984; Schultz, 1990), which has prompted the investigators to pay special attention to this variable. A growing number of studies (Anthony Bergstone, 1988; Fitting, 1986; Noelker, 1985; Pruncho, 1989) also provide evidence of gender differences in mental health responses to the caretaking task, suggesting that women caretakers are more adversely affected than their male counterparts.

THEORETICAL FRAMEWORK

The proposed care plan is both theoretically and empirically driven. The overall theoretical framework for this research is person-environment fit, a concept that is derived from systems theory and emphasizes the interrelatedness of systems and their subsystems (Wolanin,

1981). Dysfunctional, socially inaccessible (Silverstone, 1983) and inappropriate behavior of patients with dementia can be more easily understood in terms of person-environment fit, in that impairment of ego-sensory, perceptual and cognitive processes affect overall ability to interact successfully with the environment (Roberts, 1988). The perspective of person-environment fit also is helpful in designing environmental interventions that are therapeutic, focusing on restitution, compensation, and accommodation of impaired functions and dysfunctional behaviors.

For the cognitively impaired, accommodation may range from passive acceptance to active readjustment. Active readjustment for patients with dementia often is expressed in behaviors that are considered dysfunctional, such as wandering (Figure 2) or refusal to perform self-care activities. Due to cognitive impairment, the patient with dementia exhibits behaviors that indicate disordered person-environment interaction. These behaviors include inability to recognize once familiar objects, the purpose of the objects and how to use them, inability to recognize family and friends, repetitive behaviors, catastrophic reactions, and situationally-inappropriate behaviors (Roberts, 1988). Therapeutic interventions focus on facilitating accommodation by modifying the environment to reduce demands on the resources of the person with dementia. Behavioral interventions, based on the patient's dysfunctionally or socially inappropriate behavior as meaningful communication, also have value, if the intervention does not increase the demand stress of the environment above the patient's tolerance threshold, as elaborated in the Progressively Lowered Stress Threshold model.

PROGRESSIVELY LOWERED STRESS THRESHOLD (PLST) MODEL

Hall and Buckwalter's Progressively Lowered Stress Threshold (PLST) model (Hall, 1987) proposes that persons with dementia-causing illness need environmental demands modified because of their declining cognitive and functional abilities. The PLST model describes the increasing inability of persons with dementia-causing illness to cope with stress due to progressive cerebral pathology and associated cognitive decline (Hall, 1987).

Both environmental and internal stressors are demands that cause the person with dementia to become anxious and agitated. If the stressful stimuli are allowed to continue or increase, behavior becomes increasingly dysfunctional, often catastrophic. The PLST model suggests that reducing stress by modifying environmental demands promotes functionally-adaptive behavior. For the purposes of this paper, the model has been modified to include the notion of controlled or managed environmental stimuli that are tailored specifically to the individual needs of caregivers in the home/community setting.

The PLST model is embedded in an orientation toward comprehensive care of the cognitively-impaired older adult and his/her family (Buckwalter, 1988). In keeping with the model, caring for persons with dementia in the community requires attention to the following elements (Buckwalter, 1989; Hall, 1987; Hall, 1988):

- Providing ongoing education for patients and families about the disease process.
- Assisting the patient and caregivers with the development of routines and strategies that enhance appropriate behavior patterns.

- Helping patient and caregivers simplify daily care tasks, such as bathing, toileting, and dressing.
- Assisting with problem-solving strategies over the course of the illness as behavior and functional abilities change.
- Locating resources and developing support networks.
- Providing ongoing emotional support and counseling for patients, caregivers, and other network members.
- Assuming a case-management role of advocacy, service coordination and liaison with the primary physician.

In order to assist caregivers in understanding patient behaviors and in planning care, the PLST model addresses three dimensions and their interactions. The dimensions are clusters of symptoms in patients, levels of patient behaviors, and staging of the disease. The symptoms of dementia-causing illnesses are conceptualized to cluster into four groups:

- Intellectual losses.
- Affective or personality losses.
- Cognitive or planning losses.
- Progressively lowered stress threshold (PLST). PLST may lead to catastrophic behavior; violent, agitated or anxious behavior, purposeful wandering; confused or agitated night awakening; noisy behavior; purposeless behavior; and compulsive, repetitive behavior and verbalizations.

The second dimension—levels of patient behaviors—includes:

- Baseline or normative behavior, which is a calm state incorporating the intellectual, affective, and cognitive losses. Clients exhibiting baseline behavior are able to function within the limits of their neurologic capacity.
- Anxious behavior occurs when the adult suffering from dementia experiences stress. Caregivers are still able to communicate with the patient, but if the stress is allowed to continue or increase, the next level of behavior ensues.
- Dysfunctional or catastrophic behavior results when the patient is unable to communicate effectively and responds to the environment inappropriately. Dysfunctional behavior usually appears suddenly and lasts a short time. Episodes increase as fatigue and stress increase throughout the day.

The levels of behavior and symptoms are related to the progression or stage of the illness. Baseline behaviors diminish as the disease progresses, and anxious and dysfunctional behaviors occur more frequently. The stress threshold decreases throughout the disease until the patient reaches the end stage.

According to the PLST model, in patients with ADRD, there are six main groups of stressors that adversely affect behavioral symptoms. These include: fatigue; change; demands to achieve beyond capabilities; multiple and competing stimuli; affective responses to

perception of losses; and physical stressors, such as illness, adverse medication interactions, or pain.

Four basic assumptions underlie the PLST model and shape care using this approach:

- The patient suffering from dementia exists in a 24-hour continuum. If the patient has a problem during the night, changes need to be implemented during the day.
- The confused and agitated patient is uncomfortable and frightened, and has a right to be comfortable.
- All behavior is rooted and has meaning. Even catastrophic behaviors may have a detectable, modifiable cause.
- All humans need some control over their person and environment, and need to be treated with unconditional positive regard.

CARE PLANNING BASED ON THE PLST MODEL

The care plan (Figure 1) targets the most disturbing behavioral symptoms associated with dementia and can be controlled by strategies that flow logically from the PLST model (Hall, 1987; Hall, 1988). A major objective of the care plan is to improve the family's competence in managing problematic behavioral symptoms, which may decrease caregiver stress, delay institutionalization of the person with ADRD, and possibly reduce the costs of ADRD care.

According to the model, reduction of environmental stress through caregiver training and care planning will result in a slower rate of deterioration of the ADRD patient's physical and behavioral functions. Specifically, because persons with dementia have less demand on their cognitive processing abilities in an environment with reduced sensory stimuli, they are expected to use their remaining cognitive abilities more effectively. In turn, this should result in greater retention of functional abilities, such as dressing, grooming, toileting, and eating (a slower rate of decline). Likewise, the diminished stress on cognitive processing is hypothesized to result in reduced anxiety and catastrophic behaviors. Thus, less anxious patients are expected to wander less, engage in more interactions with family, and require fewer chemical and physical restraints.

SUMMARY

Management strategies for persons with ADRD at home are necessary in order to provide caregivers with concrete interventions that will assist in caring for the ADRD patient. With systematic interventions, physical and behavioral symptoms should decline more slowly, and the ADRD patient will be more manageable at home.

IMPLICATIONS FOR NURSES

Patient teaching for in-home caregivers of ADRD patients is accomplished in a variety of settings. Nurses in acute care settings, physicians' offices, and public health nurses must provide a comprehensive overview of behavioral management techniques within a relatively brief time span, generally an hour.

The PLST care plan provides a comprehensive, yet simple framework allowing nurses maximum flexibility to individualize care to meet the in-home caregivers' preferences and needs for autonomy. Caregivers express satisfaction at being able to plan care based on prior understanding of the patient's personality and new knowledge of ADRD-related needs. The PLST care plan assists nurses to help caregivers rapidly identify potential sources of problem behavior and select interventions appropriate to the causative factors. Moreover, the care plan establishes a common language between nurses and caregivers when discussing patient needs and evaluating outcomes.

In addition, nurses using the PLST care plan recognize a systematic approach to finding alternatives to chemical restraints when working with ADRD patients with secondary symptoms such as wandering. Within the six categories of stressors, suggestions for activities, daily structure, rest periods, minimizing inappropriate stimuli, and maintaining comfort provide a wide variety of approaches before using chemical approaches.

The PLST care plan provides nurses with insight into behavior of ADRD patients that appear to be random and unmanageable. This can be applied to new, more diverse nursing settings, such as adult day care and group homes.

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KEYPOINTS

1. Family-provided care of members with Alzheimer's disease and related disorders (ADRD) is complicated by the presence of secondary behavioral symptoms, such as agitation, that lead to caregiver depression, burden, and breakdown.
2. Caregiver education to manage secondary symptoms in ADRD can be simplified by using a theoretical framework of person-environment fit, providing a selection of interventions to modify the environment to reduce demand on the dwindling resources of the demented person.
3. The Progressive Lowered Stress Threshold (PLST) model identifies six areas of stress for persons with ADRD fatigue, change of caregiver, environment or routine, demands to achieve beyond capability, multiple and competing stimuli, affective response to perceived losses, and physical stressors.

Standard In-Home Care Plan for Person With Alzheimer's Disease or Related Disorder

Problem/Need	Patient Progress (Short-Term Goal)	Interventions
Loss of cognition	Patient will be adequately stimulated and experience no anxiety	Collect baseline assessment on patient behavior. Train caregiver, in advance, to prevent fearfulness. Individualize care plan.
Loss of planning	Patient will be able to function in routine without needing plan	Develop a routine schedule that the patient can follow daily.
Loss of stress tolerance	Patient will be free of agitation and sleep well at night	Have patient in recliner or spend quiet time in room for about 40 minutes at 10 a.m. and 90 minutes at 2 p.m. If patient resists resting, try decreasing environmental noise and relaxing yourself. Additional time out may be needed for about 30 minutes at 5:30. Use afghans and environmental cues to define rest periods. Do not plan activities or have visitors at that time. Avoid caffeine. Train caregiver to recognize anxiety and building tension. When anxiety is noted, remove the patient to a quiet area and allow to "gather wits."
Loss of recent memory	Patient will remain calm	Avoid reality testing. Avoid reality orientation unless patient requests it or safety is threatened. Use reminiscence and validation therapy. Recognize that behavior may be rooted in past or perceptions of the present.
Decreased ability to perceive multiple stimuli	Patient will have appropriate response to stimuli	Avoid misleading and frightening stimuli. This may include television, mirror images, pictures depicting animals or humans, and some geometric images. Avoid music, except "easy listening" music, music from the person's era, or favorite music prior to illness. Use one-to-one activities or small groups. Simplify activities, for example, sorting, stacking, gross motor activities. Use activities that appeal to basic sense of touch, taste, smell. Remove shine from floors.
Loss of ability to choose and decide	Patient will experience no frustration	Lay out clothing for patient. If changing clothing confuses patient, have all clothing alike. Minimize simple choices and decisions if patient is unable to respond or becomes frustrated. Simplify mealtime with fewer utensils and food choices, if needed. When the patient is unable to use utensils, encourage eating finger foods. Do not force patient to make choices when he/she experiences difficulty with decisions; however, try to provide as many options as the patient can handle.

Standard In-Home Care Plan for Person With Alzheimer's Disease or Related Disorder

Problem/Need	Patient Progress (Short-Term Goal)	Interventions
Loss of time sense	Patient will sleep at night and will not wake others when awake.	If the patient is up at night, increase the number or duration of rest periods during the day. Allow yourself to rest when the patient rests. Feed snack at bedtime. If up, take to toilet. Do not restrain in bed. Use photosensitive nightlights for consistent low-level light. If the patient arises, do not turn on light, as it cues him/her that it is morning.
Weight loss	Patient will maintain weight	Provide extra time and quiet with one or two other individuals when eating. Prepare favorite foods and snacks. Encourage more frequent small meals per day (eg, six). If patient enjoys certain foods, offer these more often, in keeping with dietary restrictions, such as for diabetes.
Communication loss	Patient and caregiver will communicate	Assess patient's ability to read, write, comprehend, and express self. Use touch to reassure when communicating. Use voice inflection, facial expression and gentle gestures to add meaning. If message is not understood, repeat it exactly. Stand in front of patient, your face at eye level or below. Allow patient the comfort of using present social graces. Always address one-to-one. Teach the caregiver to recognize abrupt behavior as symptomatic (a signal that the patient is stressed).
Fearfulness	Patient will be free of fear	Allow increased time for all activities. Use reminiscence and validation to increase self-esteem. Use social skills to give care recipient control in fearful situation. If confused or agitated, decrease stimulus and simplify routine. Have soft, reassuring colors and objects. Reassure patient he/she is safe and that the caregiver will assist.
Loss of bowel and bladder function	Patient will be continent, incontinence will be managed	Provide a regular schedule of bathroom visits. Avoid using oral laxatives or enemas, as they will decrease the patient's control. Use fiber, fluid, and exercise instead. May limit fluid after 6 p.m., if patient is adequately hydrated.
Loss of concern for safety	Patient and others will be free of injuries	Client will be supervised during bathing, while eating, and during activities. Stairs and doors will be carefully monitored by caregiver, including the use of door alarms or locks, whenever possible. Clients will not have access to objects such as coffee pots, radiators or hot-water taps, without supervision. Medications and potentially hazardous substances, such as shaving lotion and household cleaners, must be used with caution and locked in a safe place while not in use. All sharp or potentially dangerous materials will be kept out of the patient's reach. Spills will be wiped up when discovered. Clients who use adaptive

Standard In-Home Care Plan for Person With Alzheimer's Disease or Related Disorder

Problem/Need	Patient Progress (Short-Term Goal)	Interventions
		devices, such as canes, in a dangerous or threatening manner shall be supervised in their use. The least restrictive, alternative measures will be explored with patients who can no longer walk, but continue to try.
Caregiver burden	Family caregiver will verbalize satisfaction with his/her ability to provide care	Have the family attend a monthly support group where they can voice their concerns about care and receive feedback from other families. It also provides opportunities for continuing education. Have family members who express social isolation or the need for more contact perform volunteer activities. Inform family caregiver of the resources available in his/her community, such as respite and adult day care, financial and legal counseling, homemakers/home health aides, VNAs, and support groups.
Visits from family and friends	Family and friends will verbalize satisfaction following a visit with the patient	<p>Family and friends should be encouraged to choose a time for visiting that is included in the person's consistent schedule. Visitors should be encouraged to visit in small groups and recognize the person's fatigue, limiting his/her visit when fatigue occurs. Visitors should be discouraged from visiting during rest hours.</p> <p>Visitors to the home should be encouraged to bring a small indication of celebration when they visit, such as flowers, food, pictures, or an object from the patient's past. Visitors can make anecdotal booklets of reminiscences to help in their visits. Visitors can be taught to participate in simple activities or administer simple adult games. Minimize visits outside if the person becomes agitated, wanders, or is up at night following an outside visit.</p>
Outcomes: <ol style="list-style-type: none"> 1. Patient will be safe and free from injury. 2. Patient will appear comfortable, expressing freedom from fear and anxiety. 3. Patient will not be restrained, except for protection from self. 4. Family will express satisfaction with care. 		

FIGURE 1.
Standard In-Home Care Plan for Person With Alzheimer's Disease or Related Disorder

Wandering

Type of Wandering	Behavioral Characteristics	Interventions
Tactile wanderers	These patients are nearing the end of the ambulatory dementia phase. They spend their time using their hands to explore the environment. Patients may appear to be blind and unable to interpret visual stimuli consistently. They remain calm and appear to wander by accident as they continue to feel their way through doorways and down halls. These patients often have lost the ability to communicate verbally.	The caregiver should guide or distract the patient from hallways and doors. For chronic wandering, door knobs and locks may be modified and alarm systems used. The patient will allow redirection to other tactile objects. The caregiver also can supervise patient walking.
Environmentally cued wandering	These patients appear calm and tend to follow cues within the environment; if they see a window, they look out. A chair may cue them to sit, or a door may indicate an exit. Hallways provide cues to continue walking. These patients wander on a regular basis and may appear to be searching. They respond well to nonrestrictive environmental barriers and concrete indicators of territory. These patients are usually in the mid-to late ambulatory dementia phase, requiring assistance for at least bathing and dressing.	The caregiver should assess the environment for cues of wandering. Doors may be disguised with all coverings that either conceal or divert patients. Windows in doors can be curtained or covered with "mirror plastic" so the patient will try to avoid contact. Special closures can be fitted to the door so the patient is unable to open it. Chairs and other cues to stop should be provided. When no barrier is present, one may be created by adhering a double line of brightly colored tape to the floor. Diversionary activities, such as music therapy, are useful in keeping the patient's attention.
Reminiscent/fantasy wandering	The patient is calm and in the ambulatory phase of the illness. The desire to wander stems from a delusion or fantasy, usually based in the person's past, for instance, a person going to work, seeing parents, or doing chores. Frequently, the person announces that he/she is leaving and is reassured that there is a specific place to go.	Depending on the intensity of the patient's mood, the caregiver first may try to gently remind the patient they he/she does not have to go to work, do chores, or see parents at that time. If this results in increased anxiety, a fantasy area might be created, based on experiences or past occupations, such as a desk with papers on it, an area for the housewife to clean up, or stacks of foam for the person to restack. The caregiver also may find that validation of the meaning of the delusion (for example, the feelings of worth associated with work) will distract the patient. Use of the term "later" and diversional activities also help.

Wandering

Type of Wandering	Behavioral Characteristics	Interventions
Recreational wandering	The patient may be in the confused or ambulatory dementia phases of the illness. The person may have a history of an active lifestyle prior to becoming ill or may have been taken for walks regularly by a caregiver. The wandering is purposeful, recurs regularly, usually at the same time, and appears to serve a need for exercise. The patient is calm, unless stopped.	The caregiver should plan to take the patient for a walk each day at the same time. Walks should follow exactly the same route each day, beginning and ending at the same place. This will help the caregiver locate the patient, should he or she wander. Walking with the patient is an excellent way for the caregiver to interact on a one-on-one basis and reminisce with the patient.
Agitated purposeful wandering	The patient is upset, agitated and/or exhibiting stress-related, problematic behavior, such as angry outburst, increased confusion. The patient is cognitively and socially inaccessible (lost). Preoccupied with leaving, the patient may pack suitcases to take home. Caregivers will be generally unable to reason with the patient and may recognize the patient's fear of them. Caregivers who attempt to remove control from the resident may be assaulted as the resident attempts to maintain control by panicking and fleeing. Once recognized, agitated purposeful wandering can be prevented.	<p>Immediate interventions:</p> <p>The caregiver should not confront the resident but try to diffuse the situation. Tell the patient about caregiver fears and concerns. Offer suggestions, such as waiting for a glass of juice, that will buy time to allow the patient to regain composure. Use preserved social skills to allow the patient maximum control of the situation. Remove offending stressors.</p> <p>If the patient leaves, accompany or follow, with a coat when appropriate. Bring back as quickly as possible, providing measures to decrease stress. Assure safety and security.</p> <p>Prevention of further episodes:</p> <p>Evaluate the cause of the incident. Reduce the amount of stimulus to which the patient is exposed, increase rest periods or attempt to decrease stressors caused by other individuals, such as negative feedback from others. This patient may benefit from a protected environment where unconditional positive regard is provided and environmental stimuli reduced.</p>

FIGURE 2.
Wandering