

DEMENTIA OF THE ALZHEIMER'S TYPE/VASCULAR DEMENTIA

DSM-IV

DEMENTIA OF THE ALZHEIMER'S TYPE (DAT)

Early Onset (At or Below Age 65)

- 290.10 Uncomplicated
- 290.11 With delirium
- 290.12 With delusions
- 290.13 With depressed mood

Late Onset (After Age 65)

- 290.0 Uncomplicated
- 290.3 With delirium
- 290.20 With delusions
- 290.21 With depressed mood

(Note: DAT should also be coded on Axis III, 331.0.)

VASCULAR DEMENTIA

- 290.40 Uncomplicated
- 290.41 With delirium
- 290.42 With delusions
- 290.43 With depressed mood

Note: In the presence of vascular dementia, the specific underlying medical cause, such as stroke, should be coded on Axis III.

(For dementias due to other general medical conditions, refer to DSM-IV for specific code listing.)

Dementia of the Alzheimer's type is a specific degenerative process occurring primarily in the cells located at the base of the forebrain that send information to the cerebral cortex and hippocampus. It is the most common form of dementia and is characterized by a steady and global decline. In comparison, vascular dementia reflects a pattern of intermittent deterioration related to multiple infarcts to various areas of the brain. Although the etiologies differ, these two forms of dementia share a common symptom presentation and therapeutic intervention.

ETIOLOGICAL THEORIES

Psychodynamics

These forms of dementia reflect a chronic organic mental disorder with progressive cognitive losses caused by damage to various areas of the brain, depending on underlying pathology. Personality change is common and may be manifested by either an alteration or accentuation of premorbid characteristics with primary deficits in memory and planning and a predisposition to confusion.

Biological Theories

Vascular dementia reflects a pattern of intermittent deterioration in the brain. Symptoms fluctuate and are determined by the area of the brain that is affected. Deterioration is thought to occur in response to repeated infarcts of the brain. Predisposing factors include cerebral and systemic vascular disease, hypertension, cerebral hypoxia, hypoglycemia, cerebral embolism, and severe head injury.

Several studies have shown that antibodies are produced in the brains of individuals with Alzheimer's disease. Although the triggering mechanism is not known, the reactions are actually autoantibody production, suggesting a possible alteration in the body's immune system. Although the exact cause of Alzheimer's disease is unknown, several hypotheses have been supported by varying amounts and quality of research data. The exception is research on environmental causes, such as the ingestion of aluminum, which to date have not been supported by research findings. Research has revealed that, in DAT, the enzyme required to produce acetylcholine is dramatically reduced, especially in the areas of the brain where the senile plaques and neurofibrillary tangles occur in the greatest numbers. This decrease in acetylcholine production reduces the amount of neurotransmitter that is released to cells in the cortex, hippocampus, and nucleus basalis, resulting in a disruption of memory processes. Additionally, the neuritic plaques that accumulate are composed of beta-amyloid, an insoluble protein that is an abnormal breakdown product of the cell membrane constituent amyloid precursor protein (APP). Furthermore, the formation of the customary plaques and tangles appears to be related to the cholesterol-transporting protein, apolipoprotein-E (ApoE), which has been associated with an earlier-than-average age of onset for the common form of Alzheimer's disease for individuals who carry the ApoE₄ genetic variant.

Thus, genetics appears to play a role. Studies suggest a familial pattern of transmission that is four times greater than in the general population. Familial, or early-onset Alzheimer's, has been linked to defects of genes on chromosomes 1, 14, or 21, with some families exhibiting a pattern of inheritance that suggests possible autosomal-dominant gene transmission. Furthermore, Down syndrome (extra chromosome 21) may have some relationship to Alzheimer's disease. At autopsy, both have many of the same pathophysiological changes, and a high percentage of individuals with Down syndrome who survive to adulthood develop Alzheimer's lesions by age 50. (Incidentally, these individuals carry two copies of the gene for APP.)

Current research suggests that Alzheimer's disease may actually be a lifelong process, with changes in the brain developing decades before the onset of dementia. Other researchers theorize that a rich education may increase a person's reserve of brain cells or connections between nerve cells, either of which could reduce the risk of dementia.

CLIENT ASSESSMENT DATA BASE

Activity/Rest

Feeling tired; fatigue may increase severity of symptoms, especially as evening approaches

Day/night reversal; wakefulness/aimless wandering, disturbance of sleep rhythms

Lethargy; decreased interest in usual activities, hobbies; inability to recall what is read/follow plot of television program; possibly forced to retire

Impaired motor skills; inability to carry out familiar, purposeful movements

Content sitting and watching others

Main activity may be hoarding inanimate objects; repetitive motions (e.g., fold-unfold-refold linen), hiding articles, or wandering

Circulation

Possible history of systemic/cerebral vascular disease, hypertension, embolic episodes (predisposing factors)

Ego Integrity

Behavior often inconsistent; verbal/nonverbal behavior may be incongruent

Suspicious or fearful of imaginary people/situations; clinging to significant other(s)

Misperception of environment, misidentification of objects/people, hoarding objects; belief that misplaced objects are stolen

Multiple losses; changes in body image and self-esteem

Emotional/ability (cries easily, laughs inappropriately); variable mood changes (apathy, lethargy, restlessness, short attention span, irritability); sudden angry outbursts (catastrophic reactions)

May deny significance of early changes/symptoms, especially cognitive changes, and/or describe vague, hypochondriacal reports (e.g., fatigue, diarrhea, dizziness, occasional headaches)
May conceal limitations (e.g., make excuses for not being able to perform tasks; thumbing through a book without reading it)
Feelings of helplessness; strong, depressive overlay; delusions; paranoia

Elimination

Urgency (may indicate loss of muscle tone)
Incontinence of urine/feces
Prone to constipation/impaction, with diarrhea

Food/Fluid

Hypoglycemic episodes (predisposing factor)
Lack of interest in/forgetting of mealtimes; dependence on others for food cooking and preparation at table, feeding, using utensils
Changes in taste, appetite; denial of hunger/refusal to eat (may be trying to conceal lost skills)
Loss of ability to chew (silent aspiration)
Weight loss; decreased muscle mass; emaciation (advanced stage)

Hygiene

May be dependent on SO to meet basic hygiene needs
Appearance disheveled, unkempt; body odor present; poor personal habits
Clothing may be inappropriate for situation/weather conditions
Misinterpretation of, or ignoring, internal cues, forgetting steps involved in toileting self, or inability to find the bathroom

Neurosensory

Concealing inabilities (may make excuses not to perform task, may thumb through a book without reading it)
Family members may report a gradual decrease in cognitive abilities, impaired judgment/ inappropriate decisions, impaired recent memory but good remote memory, behavioral changes/individual personality traits altered or exaggerated
Loss of proprioception sense (location of body/body parts in space)
Primitive reflexes (e.g., positive snout, suck, palmar) may be present
Facial signs/symptoms dependent on degree of vascular insults
Seizure activity (secondary to the associated brain damage) may be reported/noted
Mental status (may laugh at or feel threatened by exams)
Disoriented to time initially, then place; usually oriented to person until late in disease process
Impaired recent memory, progressive loss of remote memory
May change answers during the interview
Difficulty in comprehension, abstract thinking
Unable to do simple calculations or repeat the names of three objects, short attention span
Hallucinations, delusions, severe depression, mania (advanced stage)
May have impaired communication: difficulty with finding correct words (especially nouns); conversation repetitive or scattered with substituted meaningless words; speech may become inaudible; gradually loses ability to write (fine motor skills) or read

Safety

History of recent viral illness or serious head trauma, drug toxicity, stress, nutritional deficits (may be predisposing/accelerating factors)
Incidental trauma (falls, burns, etc.); presence of ecchymosis, lacerations
Disturbance of gait
Striking out/violence toward others

Social Interactions

Possibly fragmented speech, aphasia, and dysphasia
May ignore rules of social conduct/inappropriate behavior
Prior psychosocial factors (individuality and personality influence present altered behavioral patterns)
Family roles possibly altered/reversed as individual becomes more dependent

Teaching/Learning

Family history of DAT (4 times greater than general population); incidence of primary degenerative dementia is more common in women (who live longer) than in men; vascular dementia occurs more often in men than in women
May present a total healthy picture except for memory/behavioral changes
Use/misuse of medications, OTC drugs, alcohol

DIAGNOSTIC STUDIES

Note: Although no diagnostic studies are specific for Alzheimer's disease, these studies are used to rule out reversible problems that may be confused with these types of dementia.

Antibodies: Abnormally high levels may be found (leading to a theory of an immunological defect).

ApoE₄: Screens for the presence of a genetic defect associated with the common form of DAT.

CBC, RPR, Electrolytes, Thyroid Studies: May determine or eliminate treatable/reversible dysfunctions (e.g., metabolic disease processes, fluid/electrolyte imbalance, neurosyphilis).

Vitamin B₁₂: May disclose a nutritional deficit, if low.

Folate Levels: Low level can affect memory function.

Dexamethasone Suppression Test (DST): Rules out treatable depression.

ECG: Rules out cardiac insufficiency.

EEG: May be normal or show some slowing (aids in establishing treatable brain dysfunctions), they may also reveal focal lesions (vascular).

Skull X Rays: Usually normal but may reveal signs of head trauma.

Vision/Hearing Tests: Rule out deficits that may be the cause of or contribute to disorientation, mood swings, altered sensory perceptions (rather than cognitive impairment).

Positron-Emission Tomography (PET) Scan, Brain Electrical Activity Mapping (BEAM), Magnetic Resonance Imaging (MRI): May show areas of decreased brain metabolism characteristic of DAT. (In the future, scans may become a screening tool to reveal early changes, such as plaque formation or development of neurofibrillary tangles, for those at risk of developing dementia.)

CT Scan: May show widening of ventricles, or cortical atrophy.

CSF: Presence of abnormal protein from the brain cells is 90% indicative of DAT.

Tropicamide (Mydriacyl) Pupil Response Test: Hypersensitive to drugs that block the action of acetylcholine. Pupil dilation response to the eyedrops seems equal in clients with mild or early-stage DAT as in severe stage; therefore, this test may provide an early screening tool but is still being researched.

Alzheimer's Disease-Associated Protein (ADAP): Postmortem studies have yielded positive results in more than 80% of DAT patients. Adaptation of ADAP for live testing is being investigated.

NURSING PRIORITIES

1. Provide safe environment; prevent injury.
2. Promote socially acceptable responses; limit inappropriate behavior.
3. Maintain reality orientation/prevent sensory deprivation/overload.
4. Encourage participation in self-care within individual abilities.
5. Promote coping mechanisms of client/significant other(s).
6. Support client/family in grieving process.
7. Provide information about disease process, prognosis, and resources available for assistance.

DISCHARGE GOALS

1. Adequate supervision/support systems available.
2. Maximal level of independent functioning achieved.
3. Coping skills developed/strengthened and SOs using available resources.
4. Disease process/prognosis and client expectations/needs understood by SO.
5. Plan in place to meet needs after discharge.

NURSING DIAGNOSIS

Risk Factors May Include:

INJURY/TRAUMA, risk for

Inability to recognize/identify danger in environment, impaired judgment

Disorientation, confusion, agitation, irritability, excitability

Weakness, muscular incoordination, balancing difficulties, altered perception (missing chairs, steps, etc.)

Seizure activity

Possibly Evidenced by:

[Not applicable; presence of signs and symptoms establishes an *actual* diagnosis.]

Desired Outcomes/Evaluation Criteria— Family/Caregiver(s) Will:

Recognize potential risks in the environment
Identify and implement steps to
correct/compensate for individual factors.

Client Will:

Be free of injury.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess degree of impairment in ability/competence, presence of impulsive behavior. Assist SO to identify any risks/potential hazards and visual-perceptual deficits that may be present.

Identifies potential risks in the environment and heightens awareness of risks so caregivers are more alert to dangers. Clients demonstrating impulsive behavior are at increased risk of injury because they are less able to control their own behavior/actions. Visual-perceptual deficits increase the risk of falls.

Eliminate/minimize identified hazards in the environment.

Monitor behavior routinely, note timing of behavioral changes, increasing confusion, hyperactivity. Initiate least restrictive interventions before behavior escalates.

Distract/redirect client's attention when behavior is agitated or dangerous (e.g., climbing out of bed).

Obtain identification jewelry (bracelet/necklace) showing name, phone number, and diagnosis.

Dress according to physical environment/individual need.

Lock outside doors as appropriate, especially in evening/night. Do not allow access to stairwell or exit. Provide supervision and activities for client who is regularly awake during night.

Be attentive to nonverbal physiological symptoms.

Be alert to underlying meaning of verbal statements.

A person with cognitive impairment and perceptual disturbances is prone to accidental injury because of the inability to take responsibility for basic safety needs or to evaluate the unforeseen consequences (e.g., may light a stove/cigarette and forget about it, mistake plastic fruit for the real thing and eat it, misjudge distance involving chairs and stairs).

Early identification of negative behaviors with appropriate action can prevent need for more stringent measures. **Note:** "Sundown syndrome" (increased restlessness, wandering, aggression) may develop in late afternoon/early evening, requiring programmed interventions and closer monitoring at this time to redirect and protect client.

Maintains safety while avoiding a confrontation that could escalate behavior/increase risk of injury.

Facilitates safe return of client if lost. Because of poor verbal ability and confusion, these persons may be unable to state address, phone number, etc. Client may wander, exhibit poor judgment, and be detained by police, appearing confused, irritable, or having violent outbursts.

The general slowing of metabolic processes results in lowered body heat. The hypothalamic gland is affected by the disease process, causing person to feel cold. Client may have seasonal disorientation and may wander out in the cold. **Note:** Leading causes of death in these clients are pneumonia and accidents.

Preventive measures can contain client without constant supervision. Activities promote involvement and keep client occupied.

Because of sensory loss and language dysfunction, may express needs nonverbally (e.g., thirst by panting; pain by sweating, doubling over). **Note:** Wandering may be a coping mechanism as client seeks a change in environment (too hot/cold, bored/overstimulated), searches for food/bathroom, or relief from discomfort (pain/adverse drug reaction).

May direct a question to another, such as, "Are you cold/tired?" meaning client is cold/tired.

Monitor for medication side effects, signs of over-medication (e.g., extrapyramidal signs, orthostatic hypotension, visual disturbances, GI upsets).

Recommend use of “child-proof locks”, secure medications, cleaning products, poisonous substances, tools, sharp objects, etc. Remove stove knobs, burners.

Provide quiet room/activity.

Avoid continuous use of restraints. Have SO/ others stay with client during periods of acute agitation.

Collaborative

Administer medications as appropriate, e.g., thioridazine hydrochloride (Mellaril).

Client may not be able to report signs/symptoms, and drugs can easily build up to toxic levels in the elderly. Dosages/drug choice may need to be altered.

As the disease worsens, the client may fidget with objects/locks (hypermetamorphosis) or put small items in mouth (hyperorality), which potentiates possibility of accidental injury/death.

Overstimulation increases irritability/agitation, which can escalate to violent outbursts.

Endangers the individual who succeeds in partial removal of restraints. May increase agitation and potentiate fractures in the elderly (owing to reduced calcium in the bones).

Short-term use of low-dose neuroleptics may moderate “sundowning” behaviors. **Note:** Condition may be related to deterioration of the suprachiasmatic nucleus of the hypothalamus (controls the sleep-wake cycle) with disturbance of circadian rhythms.

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

Desired Outcomes/Evaluation Criteria—

Client Will:

Family/Caregiver Will:

CONFUSION, chronic

Irreversible neuronal degeneration

Altered interpretation/response to stimuli

Progressive/long-standing cognitive impairment; impaired short-term memory

Altered personality; impaired socialization

Clinical evidence of organic impairment

Experience a decrease in level of frustration, especially **when participating in ADLs.**

Verbalize understanding of disease process and client’s needs.

Identify/participate in interventions to deal effectively with situation.

Provide for maximal independence while meeting safety need of clients.

Initiate behaviors/lifestyle changes to maximize client’s cognitive functioning.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess degree of cognitive impairment (e.g., changes in orientation to person, place, time; attention span; thinking ability). Talk with SO about changes from usual behavior/length of time problem has existed.

Provides baseline for future evaluation/ comparison, and influences choice of interventions. **Note:** Repeated evaluation of orientation may actually heighten negative responses/client's level of frustration.

Maintain a pleasant, quiet environment.

Reduces distorted input, whereas crowds, clutter, and noise generate sensory overload that stresses the impaired neurons.

Approach in a slow, calm manner.

This nonverbal gesture lessens the chance of misinterpretation and potential agitation. Hurried approaches can startle and threaten the confused client who misinterprets or feels threatened by imaginary people and/or situations.

Face the individual when conversing.

Maintains reality, expresses interest, and arouses attention, particularly in persons with perceptual disturbances.

Address client by name.

Names form our self-identity and establish reality and individual recognition. Client may respond to own name long after failing to recognize SO.

Use lower voice register and speak slowly to client.

Increases the chance for comprehension. High-pitched, loud tones convey stress and anger, which may trigger memory of previous confrontations and provoke an angry response.

Give simple directions, one at a time, or step-by-step instructions, using short words and simple sentences.

As the disease progresses, the communication centers in the brain become impaired, hindering the individual's ability to process and comprehend complex messages. Simplicity is the key to communicating (both verbally and nonverbally) with the cognitively impaired person.

Pause between phrases or questions. Give hints and use open-ended phrases when possible.

Invites a verbal response and may increase comprehension. Hints stimulate communication and give the person a chance for a positive experience.

Listen with regard despite content of client's speech.

Conveys interest and worth to the individual.

Interpret statements, meanings, and words. If possible, supply the correct word.

Assisting the client with word processing aids in decreasing frustration.

Reduce provocative stimuli: negative criticism, arguments, confrontations.

Any provocation decreases self-esteem and may be interpreted as a threat, which may trigger agitation or increase inappropriate behavior.

Use distraction. Talk about real people and real events when client begins ruminating about false ideas, unless talking realistically increases anxiety/agitation.

Rumination promotes disorientation. Reality orientation increases client's sense of reality, self-worth, and personal dignity.

Refrain from forcing activities and communications. Change activity if client loses interest in present activity.

Use humor with interactions.

Focus on appropriate behavior. Give verbal feedback, positive reinforcement (e.g., a pat on the back, applause). Use touch judiciously and respect individual's personal space/response.

Respect individuality and evaluate individual needs.

Allow personal belongings.

Permit hoarding of safe objects.

Create simple, noncompetitive activities paced to the individual's abilities. Provide entertaining, memory-stimulating music, videos, TV programs. Engage in old hobbies, preferred activities (e.g., arts/crafts, music, supervised cooking, gardening, spiritual programs).

Make useful activities (jobs) out of hoarding and repetitive motions, (e.g., collecting junk mail, creating scrapbook, folding/unfolding linen, bouncing balls, dusting, sweeping floors).

Provide several drawers/baskets that are acceptable to rummage through. Fill with safe items that would be of interest to client, e.g., yarn balls, quilt blocks, fabrics with different texture and colors; baby clothes, pictures, costume jewelry (without pins), small tools, sports magazines.

Help client find misplaced items, label drawers/belongings. Do not challenge client.

Monitor phone use closely. Post significant phone numbers in prominent place, secure long-distance numbers.

Force decreases cooperation and may increase suspiciousness, delusions. Changing activity maintains interest and reduces restlessness and possibility of confrontation.

Laughter can assist in communication and help reverse emotional/ability.

Reinforces correctness, appropriate behavior. A focus on inappropriate behavior can encourage repetition. Although touch frequently transcends verbal interchange (conveying warmth, acceptance, and reality), the individual may misinterpret the meaning of touch, and intrusion into personal space may be interpreted as threatening because of the client's distorted perceptions.

Persons experiencing a cognitive decline deserve respect, dignity, and recognition of worth as an individual. Client's past and background are important in maintaining self-concept, planning activities, communicating, etc.

Familiarity enhances security, sense of self, and decreases feelings of loss/deprivation.

This activity may preserve security and counterbalances irrevocable losses.

Motivates client in ways that will reinforce usefulness and self-worth and stimulate reality.

May decrease restlessness and provide option for pleasurable activity. Having a "job" helps client feel useful.

Availability of this kind of assortment provides stimulation that enhances the sense and promotes memories of past life experiences.

May decrease defensiveness when client believes he or she is being accused of stealing a misplaced, hoarded, or hidden item. To refute the accusation will not change the belief and may invite anger.

Can be used as reality orientation. However, client may forget time of day when making calls, try to call dead relative, etc. Impaired judgment does not allow for distinguishing long-distance numbers and makes client easy prey for phone sales pitches.

Evaluate sleep/rest pattern and adequacy. Note lethargy, increasing irritability/confusion, frequent yawning, dark circles under eyes.

Monitor for medication side effects, signs of overmedication.

Collaborative

Administer medications as individually indicated:

Antipsychotic: e.g., haloperidol (Haldol), thioridazine (Mellaril);

Vasodilators: e.g., cyclandelate (Cyclospasmol);

Ergoloid meylates (Hydergine LC);

Tacrine (Cognex);

Donepezil hydrochloride (Aricept);

Anxiolytic agents: diazepam (Valium), lorazepam (Ativan), chlordiazepoxide (Librium), oxazepam (Serax);

Lack of sleep can impair cognitive function and coping abilities. (Refer to ND: Sleep Pattern disturbance.)

Drugs can easily build up to toxic levels in the elderly, aggravating confusion. Dosages/drug choice may need to be altered.

Small dosages may be used to control agitation, delusions, hallucinations. Mellaril is often preferred because there are fewer extrapyramidal side effects (e.g., dystonia, akathisia), visual problems, and especially gait disturbances. **Note:** Phenothiazines may cause oversedation, excitation, or bizarre reactions. Presence of postural hypotension increases the risk of falls and development of constipation, requiring inclusion of a bowel program.

May improve mental function but requires further research.

A metabolic enhancer (increases brain's ability to metabolize glucose and use oxygen) that has few side effects. Although it does not increase cognition and memory, it may make client more alert and less anxious/depressed. However, it may be of little value in dementia therapy because there is usually only a limited degree of improvement.

Note: This drug is expensive, and families need accurate information to make informed therapy decisions and avoid false hopes and disappointment resulting from a lack of dramatic improvement.

Elevates acetylcholine levels in the cerebral cortex to improve cognition and functional autonomy in mild to moderate dementia. Cognex does not appear to alter the course of the disease, and its effects may lessen as the disease advances.

Note: Drug may be toxic to liver, but effect is reversible.

Clinical trials have demonstrated improvement in clients with mild to moderately severe Alzheimer's disease by blocking the breakdown of acetylcholine; this drug, however, has fewer side effects than cognex.

More useful in early/mild stages, for relief of anxiety. It can increase confusion/paranoia in the elderly. **Note:** Serax may be preferred because it is shorter-acting.

Thiamine;

Studies are currently underway to verify the usefulness of high doses of thiamine during the early phase of the disease to slow progression of impairment/slightly improve cognition.

Investigational use of drugs approved for other uses, e.g.: NSAIDs, such as ibuprofen (Motrin); estrogen; vitamin E, selegiline (Eldepryl); and prednisone.

These drugs are being studied for possible benefit of treatment or for delaying the onset/progression of DAT.

NURSING DIAGNOSIS**SENSORY-PERCEPTUAL alterations (specify)****May be Related To:**

Altered sensory reception, transmission, and/or integration (neurological disease/deficit)

Socially restricted environment (homebound/institutionalized)

Sleep deprivation

Possibly Evidenced by:

Changes in usual response to stimuli (e.g., spatial disorientation, confusion, rapid mood swings)

Change in problem-solving abilities; altered abstraction/conceptualization

Exaggerated emotional responses (e.g., anxiety, paranoia, and hallucinations)

Inability to tell position of body parts

Diminished/altered sense of taste

**Desired Outcomes/Evaluation Criteria—
Client Will:**

Demonstrate improved/appropriate response to stimuli.

Caregiver(s) Will:

Identify/control external factors that contribute to alterations in sensory/perceptual abilities.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Assess degree of impairment and how it affects the individual, including hearing/visual deficits.

Although brain involvement is usually global, a small percentage of clients may exhibit asymmetrical involvement, which may cause the client to neglect one side of the body (unilateral neglect). Client may not be able to locate internal cues, recognize hunger/thirst, perceive external pain, or locate body within the environment.

Encourage use of corrective lenses and hearing aids, as appropriate.

May enhance sensory input, limit/reduce misinterpretation of stimuli.

Maintain a reality-oriented relationship and environment.

Provide clues for 24-hour reality orientation with calendars, clocks, notes, cards, signs, music, seasonal hues, scenic pictures; color-code rooms.

Provide quiet, nondistracting environment when indicated (e.g., soft music, plain but colorful wallpaper/paint).

Provide touch in a caring way.

Engage client in individually meaningful activities, supporting remaining abilities and minimizing failures (e.g., daily living skills including meal preparation, setup/cleaning activities, making bed, gardening/watering plants).

Use sensory games to stimulate reality (e.g., smell mentholated ointment and tell of the time mother used it on client; use of spring/fall nature boxes).

Indulge in periodic reminiscence (old music, historical events, photos/mementoes, videos).

Provide intellectual activities (e.g., word games, review of current events, storytime, travel discussions).

Include in Bible study group, church activities, TV services for shut-ins; or arrange for visitation by clergy/spiritual advisor as appropriate.

Encourage simple outings, short walks.
Monitor activity.

Promote balanced physiological functions using colorful Nerfballs/beachballs or beanbags for tossing; target games; marching, dancing, or arm dancing with music.

Involve in activities with others as dictated by individual situation (e.g., one-to-one visitors; animal visitation; socialization groups at an Alzheimer center; occupational therapy to include crafts, paintings/finger paints, modeling clay, etc).

Reduces confusion and promotes coping with the frustrating struggles of misperception and being disoriented/confused.

Dysfunction in visual-spatial perception interferes with the ability to recognize directions and patterns, and the client may become lost, even in familiar surroundings. Clues are tangible reminders that aid recognition and may permeate memory gaps, increasing independence.

Helps to avoid visual/auditory overload, by emphasizing qualities of calmness, consistency. (**Note:** Patterned wallpaper may be disturbing to the client.)

May enhance perception to self/body boundaries.

Supports client's dignity, familiarizes individual with home/community events and enables him or her to experience satisfaction and pleasure.

Communicates reality through multiple channels.

Stimulates recollections, awakens memories, aids in the preservation of self/individuality via past accomplishments; increases feelings of security, while easing adaptation to a changed environment.

Stimulates remaining cognitive abilities and provides a sense of normalcy.

Provides opportunity to meet spiritual needs and to maintain connection with religious beliefs; may help reduce sense of isolation from humanity.

Outings refresh reality and provide pleasurable sensory stimuli, which may reduce suspiciousness/hallucinations caused by feelings of imprisonment. Motor functioning may be decreased, because nerve degeneration results in weakness, decreasing stamina.

Preserves mobility (reducing the potential for bone loss and muscle atrophy); provides diversional activity and opportunity for interaction with others.

Provides opportunity for the stimulation of participation with others and may maintain some level of social interaction.

NURSING DIAGNOSIS**May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—
Client Will:**

FEAR

Decreases in functional abilities

Public disclosure of disabilities

Further mental/physical deterioration

Social isolation

Apprehension, irritability; defensiveness; suspiciousness

Aggressive behavior

Demonstrate more appropriate range of feelings
and lessened fear.

ACTIONS/INTERVENTIONS**RATIONALE**

IndependentNote change of behavior, suspiciousness,
irritability, defensiveness.

Identify strengths the individual had previously.

Deal with aggressive behavior by imposing calm,
firm limits.Provide clear, honest information about
actions/events.Discuss feelings of SO/caregivers. Acknowledge
normalcy of feelings/concerns and provide
information as needed.Change in moods may be one of the first signs of
cognitive decline, and the client, fearing
helplessness, tries to hide the increasing inability
to remember and engage in normal activities.Facilitates assistance with communication and
management of current deficits.Acceptance can reduce fear and lessen progression
of aggressive behavior.Assists in maintaining trust and orientation as
long as possible. When the client knows the truth
about what is happening, coping is often
enhanced, and guilt over what is imagined
is decreased.Client senses but may not understand reaction of
others. This may heighten client's sense of
anxiety/fear.

NURSING DIAGNOSIS**May Be Related to:****Possibly evidenced by:****GRIEVING, anticipatory**Client awareness of something "being wrong" with changes in
memory/family reaction, physiopsychosocial well-being

Family perception of potential loss of loved one

Expressions of distress/anger at potential loss

Choked feelings, crying

Alteration in activity level, communication patterns, eating
habits, and sleep patterns

Desired Outcomes/Evaluation Criteria—

Express concerns openly.

Client/Family Will:

Discuss loss and participate in planning for the future.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess degree of deterioration/level of coping.

Information is helpful to understand how much the client is capable of doing to maintain highest level of independence and to provide encouragement to help individuals deal with losses.

Provide open environment for discussion. Use therapeutic communication skills of Active-listening, acknowledgment, etc.

Encourages client/SOs to discuss feelings and concerns realistically.

Note statements of despair, hopelessness, “nothing to live for,” expressions of anger.

May be indicative of suicidal ideation. Angry behavior may be client’s way of dealing with feelings of despair.

Respect desire not to talk.

May not be ready to deal with or share grief.

Be honest; do not give false reassurances or dire predictions about the future.

Honesty promotes a trusting relationship. Expressions of gloom, such as, “You’ll spend the rest of your life in a nursing home,” are not helpful. (No one knows what the future holds.)

Discuss with client/SOs ways they can plan together for the future.

Having a part in problem-solving/planning can provide a sense of control over anticipated events.

Assist client/SO to identify positive aspects of the situation.

Ongoing research, possibility of slow progression may offer some hope for the future.

Identify strengths client and SO see in self/situation and support systems available.

Recognizing these resources provides opportunity to work through feelings of grief.

Collaborative

Refer to other resources (e.g., support groups, counseling, spiritual advisor).

May need additional support/assistance to resolve feelings.

NURSING DIAGNOSIS

SLEEP PATTERN disturbance

May Be Related to:

Sensory impairments

Psychological stress (neurological impairment)

Changes in activity pattern

Possibly Evidenced By:

Changes in behavior and performance, irritability
Disorientation (day/night reversal)
Wakefulness/interrupted sleep, increased aimless wandering;
inability to identify need/time for sleeping
Lethargy, dark circles under eyes, frequent yawning

**Desired Outcomes/Evaluation Criteria—
Client Will:**

Establish adequate sleep pattern, with wandering
reduced.
Report/appear rested.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Provide for adequate rest. Restrict daytime sleep as appropriate; increase interaction time between client and family/staff during day, then reduce mental activity late in the day.

Although prolonged physical and mental activity results in fatigue, which can increase confusion, programmed activity without overstimulation promotes sleep.

Avoid use of continuous restraints.

Potentiates sensory deprivation, increases agitation, and restricts rest.

Evaluate level of stress/orientation as day progresses.

Increasing confusion, disorientation, and uncooperative behaviors (“sundowner’s syndrome”) may interfere with attaining restful sleep pattern.

Adhere to regular bedtime schedule and rituals.
Tell client that it is time to sleep.

Reinforces that it is bedtime and maintains stability of environment. **Note:** Later-than-normal bedtime may be indicated to allow client to dissipate excess energy and facilitate falling asleep.

Provide evening snack, warm milk, bath, back rub/
general massage with lotion.

Promotes relaxation and drowsiness and helps to address skin-care needs.

Reduce fluid intake in the evening.
Toilet before retiring.

Decreases need to get up to go to the bathroom/incontinence during the night.

Provide soft music or “white noise.”

Reduces sensory stimulation by blocking out other environmental sounds that could interfere with restful sleep.

Allow to sleep in shoes/clothing if client demands.

Providing no harm is done, altering the “normal” lessens the rebellion and allows rest.

Avoid use of diphenhydramine (Benadryl).

Once used for sleep, this drug is now contraindicated because it interferes with the production of acetylcholine, which is already inhibited in the brains of clients with DAT.

NURSING DIAGNOSIS**SELF-CARE DEFICIT (specify level)**

May Be Related to:

Cognitive decline, physical limitations

Possibly Evidenced by:

Frustration over loss of independence, depression

Impaired ability to perform ADLs (e.g., frustration; forgetfulness, misuse/misidentification of objects; inability to bring food from receptacle to mouth; inability to wash body part(s), regulate water temperature; impaired ability to put on/take off clothing; difficulty completing toileting tasks)

**Desired Outcomes/Evaluation Criteria—
Client Will:**

Perform self-care activities within level of own ability.

Caregiver Will:

Identify and use personal/community resources that can provide assistance; support client's independence.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Identify reason for difficulty in self-care, e.g., physical limitations in motion, apathy/depression, cognitive decline (such as apraxia), or room temperature ("too cold to get dressed").

Underlying cause affects choice of interventions/strategies. Problem may be minimized by changes in environment or adaptation of clothing, etc.; or may be more complex, requiring consultation from other specialists. Important to distinguish between partial and total dependence to avoid creating excess disability. **Note:** Clients reported to be unable to perform specific ADLs are often able to

Supervise, but allow as much autonomy as possible.
Allot plenty of time to perform tasks.

Assist with neat dressing/provide colorful clothes.

Offer one item of clothing at a time, in sequential order. Talk through each step of the task one at a time. Allow the wearing of extra clothing if client demands.

Provide reminders for elimination needs. Involve in bowel/bladder program as appropriate.

Assist with and provide reminders for pericare after toileting/incontinence.

Eases the frustration over lost independence.

Tasks that were once easy (e.g., dressing, bathing) are now complicated by decreased motor skills or cognitive and physical changes. Time and patience can reduce chaos resulting from trying to hasten this process.

Enhances esteem; may diminish sense of sensory loss and convey aliveness.

Simplicity reduces frustration and the potential for rage and despair. Guidance reduces confusion and allows autonomy. Altering the “normal” may lessen rebellion.

Loss of control/independence in this self-care activity can have a great impact on self-esteem and may limit socialization. (Refer to ND: Constipation.)

Good hygiene promotes cleanliness and reduces risks of skin irritation and infection.

NURSING DIAGNOSIS**NUTRITION: altered, risk for less/more than body requirements****Risk Factors May Include:**

Sensory changes

Impaired judgment and coordination

Agitation; forgetfulness, regressed habits, and concealment

Possibly Evidenced by:[Not applicable; presence of signs and symptoms establishes an *actual* diagnosis.]**Desired Outcomes/Evaluation Criteria—**

Ingest nutritionally balanced diet.

Client Will:Maintain/regain appropriate weight.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Assess SO/client's knowledge of nutritional needs.

Identifies needs to assist in formulating individual teaching plan. A role-reversal situation can occur (e.g., child now cooking for parent, husband taking over "duties" of wife), increasing the need for information.

Determine amount of exercise/pacing client does.

Nutritional intake may need to be adjusted to meet needs related to individual energy expenditure.

Offer/provide assistance in menu selection.

Poor judgment may lead to poor choices; client may be indecisive/overwhelmed by choices and/or unaware of the need to maintain elemental nutrition. **Note:** In general, metabolic rate decreases with age, requiring caloric adjustment that must be balanced with activity.

Provide privacy when eating habits become an insoluble problem. Accept eating with hands, spills, and whimsical mixtures (e.g., salad dressing in milk, salt and pepper on ice cream). Avoid solo dining or separating client from other people too early in the disease process.

Socially unacceptable and embarrassing eating habits develop as the disease progresses. Acceptance preserves esteem; decreases irritability or refusal to eat as a result of anger, frustration. Early separation can result in client feeling upset and rejected and can actually result in decreased food intake.

Offer small feedings and/or snacks of 1 or 2 foods around the clock as indicated.

Large feedings may overwhelm the client, resulting either in complete abstinence or gorging. Small feedings may enhance appropriate intake. Limiting number of foods offered at a single time reduces confusion regarding which food to choose.

Simplify steps of eating (e.g., serve food in courses). Anticipate needs, cut foods, provide soft/finger

Promotes autonomy and independence; decreases potential frustration/anger over lost abilities.

foods.

Coordination decreases as the disease progresses, which impairs the client's ability to chew and handle utensils.

Provide ample time for eating.

A leisurely approach aids digestion and decreases the chance of anger precipitated by rushing.

Place food items in pita bread/paper sack for the client who paces.

Carrying food may encourage client to eat.

Avoid baby food and excessively hot foods.

Baby foods lack adequate nutritional content, fiber, and taste for adults, and can add to client's humiliation. Hot foods may result in mouth burns and/or refusal to eat.

Observe swallowing ability; monitor oral cavity.

Diminished abilities may result in client/caregiver repeatedly placing food in client's mouth, which is not swallowed, increasing risk of aspiration.

Stimulate oral-suck reflex by gentle stroking of the cheeks or stimulating the mouth with a spoon.

As the disease progresses, the client may clench teeth and refuse to eat. Stimulating the reflex may increase cooperation/intake.

Collaborative

Refer to dietitian.

Assistance may be needed to develop nutritionally balanced diet individualized to meet client needs/food preferences.

NURSING DIAGNOSIS

CONSTIPATION (specify)/BOWEL INCONTINENCE/URINARY ELIMINATION, altered

May Be Related to:

Disorientation; inability to locate the bathroom/recognize need
Lost neurological functioning/muscle tone
Changes in dietary/fluid intake

Possibly Evidenced by:

Urgency/inappropriate toileting behaviors
Incontinence/constipation

Desired Outcomes/Evaluation Criteria— Client Will:

Establish adequate/appropriate pattern of elimination.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess prior pattern and compare with current situation.

Provides information about changes that may require further assessment/intervention.

Locate bed near a bathroom when possible; make signs for/color-code door. Provide adequate lighting, particularly at night.

Take client to the toilet at regular intervals. Dictate each step one at a time and use positive reinforcement.

Establish bowel/bladder training program. Promote client participation to level of ability.

Encourage adequate fluid intake during the day (at least 2 liters, as appropriate), diet high in fiber and fruit juices. Limit intake during the late evening and at bedtime.

Avoid a sense of hurrying/being rushed.

Be alert to nonverbal cues (e.g., restlessness, holding self, or picking at clothes).

Be discreet and respect person's privacy.

Convey acceptance when incontinence occurs. Change promptly; provide good skin care.

Record frequency of voidings/bowel movements.

Monitor appearance/color of urine; note consistency of stool.

Collaborative

Administer stool softeners, bulk expanders (e.g., Metamucil), or glycerin suppository, as indicated.

Promotes orientation/finding bathroom. Incontinence may be attributed to inability to find a toilet.

Adherence to a daily and regular schedule may prevent accidents. Frequently the problem is forgetting how to toilet (e.g., pushing pants down, positioning).

Stimulates awareness, enhances regulation of body function, and helps to avoid accidents.

Essential for bodily functions and prevents potential dehydration/constipation. Restricting intake in evening may reduce frequency/incontinence during the night.

Hurrying may be perceived as intrusion, which leads to anger and lack of cooperation with activity.

May signal urgency/inattention to cues and/or inability to locate bathroom.

Although the client is confused, a sense of modesty is often retained.

Acceptance is important to decrease the embarrassment and feelings of helplessness that may occur during the changing process. Prompt changing reduces risk of skin irritation/breakdown.

Provides visual reminder of elimination and may indicate need for intervention.

Detection of changes provides opportunity to alter interventions to prevent complications or acquire treatment as indicated (e.g., constipation/urinary infection).

May be necessary to facilitate/stimulate regular bowel movement.

NURSING DIAGNOSIS**SEXUAL dysfunction, risk for****Risk Factors May Include:**

Altered body function/progression of disease: decrease in habit/control of behavior, confusion; forgetfulness and disorientation to place or person

Lack of intimacy/sexual rejection by SO

Lack of privacy

Possibly Evidenced by:

[Not applicable; presence of signs and symptoms establishes an *actual* diagnosis.]

Desired Outcomes/Evaluation Criteria—

Meet sexuality needs in an acceptable manner.

Client Will:

Experience fewer/no episodes of inappropriate behavior.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Assess individual needs/desires/abilities of client and partner.

Alternative methods need to be designed for the individual situation to fulfill the need for intimacy and closeness.

Encourage partner to show affection/acceptance.

The cognitively impaired person retains the basic needs for affection, love, acceptance, and sexual expression.

Ensure privacy, or encourage home visitation as appropriate.

Sexual expression or behaviors may differ. The individual may masturbate, expose self. Privacy allows sexual expression without embarrassment and the objections of others.

Use distraction, as indicated. Remind client that, when in a public area, current behavior is unacceptable.

This tool is useful when there is inappropriate/objectionable behavior (e.g., self-exposure).

Provide time to listen/discuss concerns of SO.

SO may need information and/or counseling about alternatives for sexual activity/aggression.

NURSING DIAGNOSIS**FAMILY COPING, ineffective: compromised/disabling****May Be Related to:**

Disruptive behavior of client

Family grief about their helplessness watching loved one deteriorate

Possibly Evidenced by:

Prolonged disease/disability progression that exhausts the supportive capacity of SO

Highly ambivalent family relationships

Family becoming embarrassed and socially immobilized

Home maintenance becoming extremely difficult, leading to difficult decisions with legal/financial considerations

**Desired Outcomes/Evaluation Criteria—
Family Will:**

Identify/verbalize resources within themselves to deal with the situation.

Acknowledge client's condition and demonstrate positive coping behaviors in dealing with situation.

Use outside support systems effectively.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Include SOs in teaching and planning for home care.

Can ease the burden of home management and increase adaptation. A comfortable and familiar lifestyle at home helps preserve the client's need for belonging.

Review past life experiences, role changes, and coping skills.

Identifies skills that may help individuals cope with grief of current situation more effectively.

Focus on specific problems as they occur, the "here and now."

Disease progression follows no set pattern. A premature focus on the possibility of long-term care or possible incontinence, for example, impairs the ability to cope with present issues.

Establish priorities.

Helps to create a sense of order and facilitates problem-solving.

Be realistic and honest in all matters.

Decreases stress that surrounds false hopes (e.g., that client may regain past level of functioning from advertised or unproven medication).

Reassess family's ability to care for client at home on an ongoing basis.

Behaviors like hoarding, clinging, unjust accusations, angry outbursts, etc. can precipitate family burnout and interfere with ability to provide effective care.

Help caregiver/family understand the importance of maintaining psychosocial functioning.

Embarrassing behavior, the demands of care, etc. may cause withdrawal from social contact.

Provide time to listen with regard to concerns/anxieties.

SOs require constant support with the multifaceted problems that arise during the course of this illness to ease the process of adaptation and grieving.

Discuss possibility of isolation. Reinforce need for support systems.

Provide positive feedback for efforts.

Acknowledge concerns generated by consideration/ decision to place client in LTC facility. Answer questions honestly, explore options as appropriate.

Encourage unlimited visitation by family/friends as tolerated by client.

Collaborative

Involve SO/family members in planning care/ problem-solving. Verify presence of Advance Directives/Durable Medical Power of Attorney.

Refer to local resources, e.g., adult day care, respite care, homemaker services, or a local chapter of Alzheimer's Disease and Related Disorders Association (ADRDA), National Family Caregivers Association (NFCA).

Refer for family counseling or to appropriate ethical committee as indicated.

The belief that a single individual can meet all the needs of the client increases the potential for physical/mental illness (caregiver role strain). **Note:** Mortality rate for primary caregivers is actually higher than for the client with DAT.

Reassures individuals that they are doing their best.

Constant care requirements may be more than can be managed by the SO and support systems. Support is needed for this difficult guilt-producing decision, which may create a financial burden as well as family disruption/dissension.

Contact with/and familiarity forms a base of reality and can provide a reassuring freedom from loneliness. Recurrent contact helps family members realize and accept situation.

Note: Family members may require ongoing support in dealing with visitation and issues of client's deterioration and their own personal needs.

Consensus may be more readily achieved when family participates in decision-making. It is important, however, to keep client's wishes in mind when making choices and to be aware of who actually has the power to make decisions for the cognitively impaired client.

Coping with these clients is a full-time, frustrating task. Respite/day care may lighten the burden, reduce potential social isolation, and prevent family burnout/caregiver role strain. ADRDA provides group support and family teaching and promotes research. Local groups provide a social outlet for sharing grief and promote problem-solving with such matters as financial/legal advice, home care, etc. NFCA also provides programs for educating caregivers/healthcare providers and a quarterly publication.

Differing opinions regarding client care/placement can result in conflict requiring professional mediation.

NURSING DIAGNOSIS**HOME MAINTENANCE MANAGEMENT, impaired/HEALTH MAINTENANCE, altered****May Be Related to:**

Progressively impaired cognitive functioning
Complete or partial lack of gross and/or fine motor skills
Significant alteration in communication skills
Ineffective individual/family coping
Insufficient family organization or planning

Possibly Evidenced by:

Unfamiliarity with resources; inadequate support systems
Overtaxed family members (e.g., exhausted, anxious)
Household members express difficulty and request help in maintaining home safely and comfortably
Home surroundings appear disorderly/unsafe
Reported or observed inability to take responsibility for meeting basic health practices

**Desired Outcomes/Evaluation Criteria—
Family/Caregiver(s) Will:**

Reported or observed lack of equipment, financial, or other resources, impairment of personal support system
Verbalize ability to cope adequately with existing situation.
Identify factors related to difficulty in maintaining a safe environment for the client.
Assume responsibility for and initiate changes supporting client safety and healthcare goals.
Demonstrate appropriate, effective use of resources (e.g., respite/day care, homemakers, support groups).

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Evaluate level of cognitive/emotional/physical functioning (level of independence).

Identifies strengths, areas of need, and how much responsibility the client may be expected to assume. (Refer to ND: Self Care deficit.)

Assess environment, noting unsafe factors and ability of client to care for self.

Determines what changes need to be made to accommodate disabilities. (Refer to ND: Injury/Trauma, risk for).

Assist client to develop plan for keeping track of/dealing with health needs.

Schedule can be helpful to maintain system for managing routine healthcare services.

Identify support systems available to client/SO (e.g., other family members, friends).

Evaluate coping abilities, effectiveness, commitment of caregiver(s)/support persons.

Collaborative

Identify alternate care sources (such as sitter/day-care facility), senior care services (e.g., homemaking, cleaning, handyman).

Refer to supportive services as needed.

Identify in home healthcare options, e.g., medical, dental, diagnostic services.

Planning and constant care is necessary to maintain this client at home. If family system is unavailable/unaware, client needs (e.g., nutrition, dental care, eye exams) can be neglected. Primary caregiver can benefit from sharing responsibilities/constant care with others. (Refer to ND: Caregiver Role Strain.)

Progressive debilitation taxes caregiver(s) and may alter ability to meet client/own needs. (Refer to ND: Family Coping, ineffective: compromised/disabling.)

As client's condition worsens, SO may need additional help from several sources or may eventually be unable to maintain client at home.

Medical and social services consultant may be needed to develop ongoing plan/identify resources as needs change.

Delivery of health care needs "on site" may prevent exacerbation of confusion, increase cooperation, and provide more accurate picture of client's status.

NURSING DIAGNOSIS

Risk Factors May Include:

Possibly Evidenced by:

Desired Outcomes/Evaluation Criteria— Caregiver Will:

CAREGIVER ROLE STRAIN, risk for

Illness severity of the care receiver; duration of caregiving required, complexity/amount of caregiving tasks

Caregiver is female; spouse

Care receiver exhibits deviant, bizarre behavior

Family/caregiver isolation; lack of respite and recreation

[Not applicable; presence of signs/symptoms establishes in *actual* diagnosis.]

Identify individual risk factors and appropriate interventions.

Demonstrate/initiate behaviors or lifestyle changes to prevent development of impaired function.

Use available resources appropriately.

Report satisfaction with plan and support available.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Note physical/mental condition, therapeutic regimen of care receiver.

Determines individual needs for planning care. Identifies strengths and how much responsibility the client may be expected to assume as well as disabilities requiring accommodation.

Determine caregiver's level of responsibility and involvement in care as well as the anticipated length of care. Use assessment tool such as Burden Interview to further determine caregiver's abilities, when appropriate.

Progressive debilitation taxes caregiver and may alter ability to meet client/own needs. (Refer to ND: Family Coping, ineffective: compromised/disabling.)

Identify strengths of caregiver and care receiver.

Helps to use positive aspects of each individual to the best of abilities in daily activities.

Discuss caregiver's view and concerns about situation.

Allows ventilation and clarification of concerns, promoting understanding.

Determine available supports and resources currently used.

Provides information regarding adequacy of supports/current needs.

Facilitate family conference to share information and develop plan for involvement in care activities as appropriate.

When others are involved in care, the risk of one person becoming overloaded is lessened.

Identify additional resources to include financial, legal, respite care.

These areas of concern can add to burden of caregiving if not adequately resolved.

Identify equipment needs/resources, adaptive aids.

Enhances independence and safety of the care receiver.

Provide information and/or demonstrate techniques for dealing with acting-out/violent or disoriented behavior.

This helps caregiver to maintain sense of control and competency. Enhances safety for caregiver and care receiver.

Stress importance of self-nurturing (e.g., pursuing self-development interests, personal needs, hobbies, and social activities).

Taking time for self can lessen risk of "burnout"/being overwhelmed by situation.

Assist caregiver to plan for changes that may be necessary for the care receiver (e.g., eventual placement in long-term care facility).

Planning for this eventuality is important for the time when burden of care becomes too great.

Collaborative

Refer to alternate-care sources (e.g., sitter/day-care facility), senior care services (e.g., meals-on-wheels/respite care) home-care agency.

As client's condition worsens, SO may need additional help from several sources to maintain client at home, even on a part-time basis.

Refer to supportive services as needed.

Medical case manager or social services consultant may be needed to develop ongoing plan to meet changing needs of client and SO/family.

NURSING DIAGNOSIS**Risk Factors May Include:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—****Client Will:****Family/Caregiver Will:****RELOCATION STRESS SYNDROME, risk for**

Little or no preparation for transfer to hospital/long-term setting

Changes in daily routine

Sensory impairment, physical deterioration

Separation from support systems

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis.]

Experience minimal disruption of usual activities.

Display limited increase in agitation.

Be aware of potential impact of changes on client.

Plan for/coordinate move as situation permits.

Recognize need to provide stability for client during adaptation period.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Discuss ramifications of move to new surroundings.

Discussing pros and cons of this decision helps those involved to reach an informed decision and feel better about/plan for the future.

Encourage visitation to facility prior to planned move.

Familiarizes family and client with new options to enable them to make informed decision.

Provide clear, honest information about actions/ events.

Decreases “surprises.” Assists in maintaining trust and orientation. When the client knows the truth about what is happening, coping may be enhanced.

Determine clients’ usual schedule of activities and incorporate into agency routine. Identify activities for SO/family participation (e.g., personal care, mealtime, exercise program).

Consistency provides reassurance and may lessen confusion and enhance cooperation. Admission to a new facility disrupts client’s routine and can intensify behavioral problems, especially in the person with cognitive dysfunctions. Presence of SO provides reassurance and may reduce sense of isolation.

Place client in private room as appropriate.

Provides opportunity to control environment and protect others from client’s disruptive behavior.

Note behavior, presence of suspiciousness/paranoia, irritability, defensiveness. Compare with SO’s description of customary responses.

Increased stress, physical discomfort/pain, and fatigue may temporarily exacerbate mental deterioration (cognitive inaccessibility) and further impair communication (social inaccessibility).

Deal with aggressive behavior by imposing firm limits; provide “time-out” as appropriate.

This represents a *catastrophic* episode that can escalate into a panic state and violence.

Calm acceptance can reduce fear and aggressive response. This defuses situation and gives the client time to regain emotional and behavioral control.