



## Study Views Visiting Patterns

*The frequency of visits by family members is generally established early in a patient's stay at a nursing facility.*

**T**HE FREQUENCY AND PATTERN OF family visits to people with dementia are generally established in the period immediately after the individual has moved into the nursing facility, according to a study published in the *Journal of Gerontology*. That means that nursing facilities seeking to enhance family involvement with patients should begin their efforts at the time of admission, the study's authors say.

The visiting patterns of primary family caregivers were studied over five years by researchers from the University of California at Los Angeles' (UCLA) Schools of Public Health and Medicine.

Facilities that reached out to families, made an effort to involve them in activities, and made visiting and other schedules more flexible increased the length and frequency of visits, several studies show.

Further, family members who provided the primary care for an individual with dementia, especially retired spouses, will likely need to continue in a caregiving role even after the individual has moved into a nursing facility. They will also be more likely to visit daily and spend many hours each week with the patient, the UCLA study found.

Several previous studies have pointed to the importance of visits to both patients and their families. Frequent family visits have been correlated with higher psychological functioning of patients, including those with dementia. And the benefits last beyond the initial period of adjustment when the

patients first move into nursing facilities, the studies indicate.

### Family Stress Levels Remain High

Although family members generally expect their stress levels to decrease with the easing of caregiving responsibilities, studies show that their stress—as it relates to money, jobs, the family as a whole, the spouse or former caregiver's loss of self, and depression—

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continues and may even increase with the addition of guilt about removing the loved one from his or her home.

Visiting can be essential in coping with this stress, studies indicate. Especially for primary family caregivers, regular visits can become an important element in the pattern of daily life as they maintain what has been a central relationship. Without it, family caregivers' sense of continuity of self can suffer, studies show. Visiting also allows family members to demonstrate their commitment and love and helps them cope with grief, loss, and

loneliness. Through surveys and face-to-face interviews with 210 family caregivers who had contacted a dementia-related association in California, UCLA researchers identified three visit-length and five visit-frequency patterns.

The group studied tended to have more than a high school education (69 percent) and were primarily Caucasian (83 percent), female (70 percent), and not employed (64 percent). More than a third were daughters caring for mothers; most of the others were the patient's spouse.

### Visiting Periods Remain Constant

Both the frequency and duration of visits declined over the five years following admission, but not by much. In the first year, family caregivers visited 3.4 times and 7.5 hours each week on average. In subsequent years, caregivers visited at least 2.6 times and 5.8 hours per week on average, even five years after admission.

In fact, the vast majority of family caregivers established and maintained stable visiting patterns soon after admission. About 90 percent visited as often in later years as in the first months after admission; of these, 37 percent (more likely to be daughters) visited once a week, 29 percent three times a week, and 14 percent (usually retired spouses) almost daily. Interestingly, daily visitors were more likely to have given their own illness or exhaustion as a reason for moving the patient into a nursing facility.

Of the 10 percent whose frequency changed, most were initially daily visi-

tors whose visits became less frequent over the course of the first year until settling into a stable, twice-weekly visiting pattern. A small percentage of family caregivers initially visited about three times per week but eventually began to visit almost daily and maintained that higher frequency through-

out the study period or until the patient's death or transfer.

Most—nearly 80 percent—spent about 3.6 hours each week with the patient and maintained that over five years or until the patient's death or transfer. About 14 percent spent about 14 hours a week visiting.

The remaining six percent, nearly all retired spouses of patients whose dementia was less severe than others, initially spent an average of 32 hours every week with their loved one, but gradually shortened their visits to about 22 hours per week. This group was also more frequently characterized by intensely negative feelings about moving their loved one into a facility. Not surprisingly, then, coupled with the amount of time they spent at the facility, this group was most likely to report having “problems” with the facility's staff.

“Many caregivers who are averse to institutionalization make promises to their spouses and parents that they will not be put in a nursing facility,” say the authors, adding that the progression of Alzheimer's disease and other dementias often makes these promises impossible to keep. The long visits, then, and possibly the complaints as well may be an attempt to expiate their guilt. “They may be trying to keep the spirit of these promises by spending as much time as possible” with the patient, the authors say.

Dissatisfaction with the facility was not correlated with family members of patients with the most severe impairments, as the authors had expected. “However, the care recipients in this study tend to be severely impaired, and their caregivers tend to be highly satisfied,” the authors say.

### Pain Management Guidelines Issued

**P**ersistent pain can cause a wide array of other physical and psychological problems if not adequately managed, say numerous studies. Problems that can result from unmanaged pain include depression, anxiety, decreased socialization, sleep disturbance, impaired ambulation and gait, slow rehabilitation, and adverse effects from multiple medications.

Between 71 and 76 percent of nursing facility patients report pain, according to various studies. Because of that, all seniors should be assessed for pain when they enter a long term care facility, say newly revised guidelines for pain management developed by the American Geriatrics Society (AGS), and pain management programs should regularly undergo quality assurance and improvement scrutiny.

Any persistent pain that affects physical or psychosocial function should be recognized as a significant problem, says AGS. Caregivers should consider providing pain medication prior to moving the patient in a way that's likely to cause pain and provide reassurance for fear-related behavior, AGS says.

**Assessments**

The initial pain assessment should record the sequence of events that led to the persistent pain complaint and establish a diagnosis, care plan, and likely prognosis. Patients with moderate to severe cognitive impairments may be more difficult to assess; including the family or caregiver in the assessment becomes essential, the guidelines say.

AGS says the assessment should:

- Identify the intensity, character, frequency or pattern, duration, location, and precipitating and relieving factors of the pain;
- Note the ways in which the pain impairs activities of daily living (ADLs) and instrumental ADLs, sleep, appetite, energy, exercise, mood, cognitive function, interpersonal relationships and intimacy, social and leisure activities, and overall quality of life;
- Record the history, effectiveness, and side-effects of the patient's analgesic use, including current and previously used prescription and over-the-counter medications, alternative therapies, and alcohol use;
- Evaluate the patient's attitudes and beliefs about pain and pain manage-

ment and his or her knowledge of pain management strategies;

- Detail the results of a careful examination of the painful area, along with common sites for pain and pain referral, focusing on the musculoskeletal and neurologic (signs of weakness or numbness) systems. Physical or

occupational therapy consultations should be considered;

- Include pertinent laboratory or other diagnostic test results; and
- Evaluate psychological function, including mood, self-efficacy, helplessness, and pain-related fears, as well as cognitive functioning. ■