

## Relocation Stress Syndrome

**R**elocation Stress Syndrome (RSS) is a nursing diagnosis characterized by confusion, agitation, behavioral and physical issues that result from a change in environment. In FTD, symptoms and behaviors are often not well understood, and the family is emotionally and physically exhausted from caregiving at the time of the move. Careful planning and coordination are especially important prior to move-in, to ease the transition to long-term residential care.

### Assessing Fit

- Use multiple pre-admission visits with residents, family members, and administrative, clinical and direct-care staff to develop rapport and assess fit. Visits should occur both at the resident's home and at the facility.
- Ensure that facility staff members are educated about how FTD symptoms, behaviors and management approaches differ from other dementias.
- Ensure that facility staff members are educated about the emotional and physical toll experienced by family caregivers, due to the particularly high burden of care in FTD.
- Inform family members about the different levels of facility care (e.g., group home, assisted living and skilled nursing) and about the ways that regulations affect how care is delivered.
- Prioritize training staff to develop understanding about the symptoms associated with behavior- and language-variant FTD, and ensure the availability of an experienced consulting psychiatrist, geriatrician or primary care provider.
- Counsel family members in FTD disease information and principles of behavioral care; connect them to AFTD through the organization's [HelpLine](#) or [website](#).
- Counsel family to be honest about the person's behavior, and to ask about and assess the facility's particular experience providing care for persons with FTD.
- Educate clinical and direct-care staff regarding the importance of adjusting their approach, as well as adjusting the care program to meet the individual needs.
- If aggression has been a concern, consider the prescription of low-dose atypical antipsychotic medication for the first few weeks after admission. Planned temporary use may avoid the need for higher doses in response to behaviors triggered by relocation.

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### Environment

- Ensure that the facility has adequate, safe inside and outside areas for residents to walk.
- Identify a room in a quieter area of the facility, and furnish it with a few familiar personal items from home, e.g., bedspread, pillow, labeled photographs or a computer (with Internet access blocking as needed).
- Consider avoiding television access in the room for the first 2 to 4 weeks to reduce the potential for misinterpreting stimuli, especially onscreen violence and anger that may exacerbate feelings of threat.
- Establish and post in the room a schedule reflecting the resident's existing daily routine as much as possible. Include: personal care, meals and activities. (*continued on next page*)

## Relocation Stress Syndrome (continued...)

### Environment, *continued*

- Use information from the resident's family and his/her personal history to inform the selection of caregiving staff, e.g., a need for male vs. female staff in personal care.
- Ensure the opportunity for one to two preferred activities that can be adapted to the new setting, e.g., continuous walking.
- Offer the resident a chair at the back of the programming room and near an exit, which will enable them to enter and exit the room easily.
- Provide increased unobtrusive monitoring by staff during the transition, to facilitate supervision to monitor for risk of elopement.
- Address the concerns of other residents and families early, directly and within compliance of HIPAA confidentiality requirements. FTD behaviors (e.g., vocalizations, rummaging and roaming) can be intrusive to other residents and their family members. Arrange a meeting with the concerned family, staff and the person living with FTD's POA, who can describe the behaviors.

### Visiting

- Treat each resident and family member as an individual. Some family members may be able to visit without issues, whereas others may need respite from caregiving at the time of admission.
- Develop a specific plan for visitation during the transition period. Frequent, brief visits with a clearly defined end may be best, e.g., immediately before a meal, limited to 15 minutes.
- Suggest a period without visits if a caregiver is extremely distressed, however, make sure that the caregiver has someone they can call daily for an update on their loved one's condition and adjustment to long-term residential care at the facility.
- Give the caregiver opportunities to make suggestions and additions, such as bringing in a favorite food or providing information on the resident's specific interests or needs, in order to help the caregiver feel included within the care team.
- Debrief caregivers after their first few weeks' visits about what they observed and any fears or concerns. Ask about how the rest of the family is adapting.
- Involve family members in the on-going assessment process to continue to develop their connections with staff, to evaluate the resident's transition, and to adjust the visiting and care plan as needed.
- Help family members to plan engaging visits that will facilitate the transition for the resident and family members; specifically address how to incorporate young children and teens who may choose to visit a parent.
- Encourage family members to participate in a family support group and to find "caregiver buddies" among other resident families.
- Encourage family questions.
- Foster continued recognition among staff of the fact that caregivers report this is the worst time of their lives.
- Always remember that the caregiver is as much of a consumer of services as the resident. Respond with empathy and foster open communication whenever possible.