Caring for older people experiencing agitation


Abstract
Agitation commonly affects older adults, particularly those living in care homes and in hospital settings. Agitation can be distressing to experience, may be associated with poorer health outcomes and can present a challenge to staff in keeping the person and those around them safe. This article examines why agitation can occur in older people and discusses current best practice, focusing on communication and non-pharmaceutical interventions. Agitation is commonly associated with dementia and delirium. This article indicates how these conditions can affect the older person and their interactions with the surrounding environment. A case study is used to illustrate application in practice.

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Aims and intended learning outcomes
This article outlines ways for nurses to care for older people that prevent and minimise agitation and promote wellbeing. The article is aimed at nurses caring for older people in hospital and care home environments, including general, mental health and community hospitals. After reading this article and completing the time activities, you should be able to:
- Explain the main causes of agitation in older people.
- Contribute to assessment of a person experiencing agitation.
- Explain how to care for agitated older adults in a person-centred way.
- Identify alternatives to pharmaceutical treatment.

Introduction
Agitation is a common symptom in medical conditions affecting older people, such as delirium and dementia (National Institute for Health and Care Excellence (NICE) 2006, 2010), but it is not a condition in its own right (Dewing 2010). It can be understood as a subjective experience of inner tension and/or as a phenomenon observable by others in the person’s behaviour, such as excessive motor activity (Howard et al 2001) or activity disturbance (Kvonen and Whitfield 2008). Other examples of agitated behaviour include verbal and physical aggression, restlessness, repetitive movements and taking clothes off inappropriately (Cohen-Mansfield 1991).
In people with dementia, these agitated behaviours are sometimes referred to as
non-cognitive symptoms or behavioural and psychological symptoms of dementia.

Older people who are agitated are more likely to receive care that focuses on containment and restraint, rather than person-centred principles (Dewling 2010), which is over-reliant on pharmaceutical interventions (Poole and Mott 2003).

This has ethical and legal implications for healthcare staff, who are required by the Mental Capacity Act 2005 to work in the best interests of people who lack capacity and to choose the least restrictive option in their care.

This article is based on the case study of Mary, a 74-year-old woman with dementia (Box 1), and explores person-centred, non-pharmaceutical ways of responding to her agitation. Mary’s case study is based on a real person and appropriate permissions have been received to use her story. Mary is a pseudonym.

Complete time out activity

Causes of agitation

Causes of agitation, such as delirium, are under-recognised and this can lead to delays in treatment and relief of symptoms (Lyketsos and Liang 1999).

Agitation may seem to happen for no reason. However, reasons usually emerge when a nurse takes time to get to know a person and their situation. Challenging behaviour is a sign that a person is in distress (NHS Protect 2013a) and has unmet needs (Stokes 2000, NHS Protect 2013a). It can be a sign that the person has a serious, life-threatening illness (NHS Protect 2013a).

Medical conditions such as delirium, dementia and depression can increase the risk of agitation and are especially common in older people (Arnold 2005). It is estimated that 50% of patients aged over 70 in UK hospitals are cognitively impaired, 27% have delirium and 8-32% are depressed (Goldberg et al 2012).

Medical conditions commonly associated with agitation in older adults are listed in Box 2.

Delirium

When agitation occurs alongside delirium, it is associated with poorer health outcomes, including increased mortality, a greater risk of complications, increased length of hospital stay, increased costs of care and an earlier move to 24-hour care (Chevrolet and Jollet 2007, NICE 2010).

Delirium, or acute confusional state, is a syndrome that can have many potential causes, such as underlying medical conditions (Arnold 2005). It is generally temporary and reversible once the underlying cause is identified and treated. The symptoms of delirium are disturbed consciousness and impaired cognitive functioning, both with a rapid acute onset and fluctuating course (NICE 2010). An individual may switch between ‘hyperactive delirium’, with agitation, restlessness and heightened arousal and ‘hypoactive delirium’, where the person withdraws and is quiet and sleepy (Schofield et al 2012). Symptoms are often worse at night and may include visual hallucinations and/or delusions.

It is estimated that 20-30% of people on medical wards in hospitals develop delirium, that 10-50% of people who have had surgery develop delirium, and that prevalence is under

BOX 1

Case study

Mary is a 74-year-old woman with severe fronto-temporal dementia who has lived in a nursing home for the past six months. She was admitted to an acute hospital with increased confusion and agitation, the cause of which is unclear.

She is accompanied by her husband, who reports that she has been displaying some unusual and distressing symptoms over the past three weeks, including:

- Increased irritability.
- Attempting to violently throw herself onto the floor.
- Pulling at her hair and clothes.
- Vigorously rubbing and pulling at her skin.
- Verbal and physical aggression while being assisted with her personal care.
- Screaming for prolonged periods.
- Night-time sleep disturbance.

| BOX 2 |

Conditions commonly associated with agitation in older adults

- Delirium:
  - Urinary tract infection or chest infection.
  - Pyrexia.
  - Dehydration.
  - Low sodium levels.
  - Anaemia.
  - Liver or kidney problems.
  - Drugs or alcohol withdrawal.
  - Epilepsy.
  - Brain injury or infection.
  - Terminal illness.
  - Constipation.

(Adapted from Royal College of Psychiatrists 2012)

Other mental health conditions:
- Psychosis, such as paranoia or hallucinations.
- Affective illness, especially mania.
- Anxiety.
- Dementia.

(Kyomen and Whitfield 2008)
0% in people in long-term care (NICE 010). Older people and those with cognitive impairment are at high risk of delirium. Patients receiving palliative care (Breitbart and Jelic 2008) and ventilated patients (Thomason et al 2005) are also at increased risk. Various medications can induce delirium, including benzodiazepines, opioids, anticholinergics and some cardiac medications, especially when multiple medicines are combined (Rudolph and Aarcantnio 2003).

Depression
Depression is a mental illness where persistent mood is seen for a period of at least two weeks, and can vary in severity from mild to severe (NICE 2009). People who are depressed may experience loss of pleasure in previously enjoyed activities, feelings of guilt and either agitation or slowed movements (NICE 2009). They may withdraw from the company of others, have difficulty sleeping, have low energy levels or have negative thoughts. Severely depressed people can have thoughts about harming themselves, be severely agitated and have psychotic symptoms. They should be referred urgently to specialist mental health services (NICE 2009). Goldberg et al (2012) estimate that between 8% and 32% of the population aged over 70 are depressed at any one time. Depression is treatable with antidepressant medications, lifestyle changes and talking therapies.

Dementia
Dementia is a clinical syndrome in which cognitive impairment and a reduced ability to manage daily life independently are generally observed (World Health Organization 2014). There are many types of dementia. Alzheimer's disease is the most common in older people, followed by vascular dementia. Two-thirds of care home residents (All-Party Parliamentary Group on dementia 2008) and one-quarter of all hospital patients (Alzheimer's Society 2012) may have dementia. Agitation in people with dementia has been described as common, persistent and stressful (Livingston et al 2014). Sourial et al (2001) found that 95% (n = 56) of people with dementia on a long-term care ward in an acute community hospital experienced at least one validated behaviour episode during the three shifts the study, within a two-week period. Agitation may arise as a direct result of dementia, but may also result from a person's interaction with their environment (Howard et al 2001), biopsychosocial oblems or unmet needs (Dewing 2010).

Sensory deficits and unmet needs
Impaired sight or hearing may increase a person's sense of vulnerability and the likelihood that situations may be misinterpreted. If a person is unable to make him or herself understood through traditional methods, he or she may communicate unmet needs for things such as water, food, exercise or comfort through agitated behaviour (Stokes 2000, James et al 2006, NHS Protect 2013a).

Stimulation
Busy environments may overstimulate cognitively impaired people and this sensory overload can be expressed through agitated behaviour (Granacher 1982, Struble and Sivertsen 1987). For example, excess noise may be difficult for the person to tolerate (Chevrolet and Jollett 2007), especially at mealtimes (Goddard and Abraham 1994). Conversely, understimulation may occur where the person is bored and craving activity and stimulation (Cohen-Mansfield 2000). Physical inactivity in people with dementia

### Box 3

**Environmental and other causes of agitation**

**Communication difficulties:**
- Sensory impairment such as poor hearing or poor vision.
- Dysphasia.

**Unmet needs:**
- Pain and/or discomfort (NICE 2006).
- Hunger or thirst.
- Need to urinate or void bowels.
- Built-up frustration from boredom, lack of social contact, lack of exercise or isolation (understimulation).
- Feeling frightened, disoriented or threatened.
- Upset as unable to find loved ones.

**Psychosocial:**
- Life history, including significant or traumatic events and occupation.
- Personality and responses to stress.
- Problems within support network.

**Environmental:**
- Disorientation as a result of confusing layout and poor signage of surrounding area.
- Uniformity, rather than contrast, in the environment.
- Building design that creates obvious flashpoints, such as locked doors interrupting the flow of walking or exits as focal points.
- Overstimulating environment, for example too much noise, too close to others or areas of high movement.
- Understimulating environment, such as being in a side room most of the time or experiencing a lack of activities (NICE 2006).
- Lack of privacy (NICE 2006).

**Other people:**
- Personal space being invaded by other confused people.
- Movement of personal possessions such as handbag, stick or frame.
- Care interventions experienced as frightening and their purpose misunderstood.
- Inadequate staff attention (NICE 2006).
- Behaviour of staff that is not person-centred.
has been strongly associated with agitation (Scherder et al 2010). Another study showed that people with dementia scream more frequently while on their own, rather than with others (Cohen-Mansfield et al 1990).

Psychosocial factors
People with dementia may feel lost and insecure in unfamiliar environments, such as hospitals, where they are unable to carry out their usual routines, are less independent and have difficulty orienting themselves (Clibbens 2011). Other factors, such as the person's life history, are relevant to understanding how they perceive the world, particularly when they are disoriented and appear to be reliving a particular time in their life. Environmental and other causes of agitation are listed in Box 3.

Staff interactions
Agitation may also be a response to the actions of others. Around half of aggressive behaviours may occur during care interventions (Beck et al 1990). Kitwood (1997) identified several ways of interacting with people with dementia that are damaging, which he termed 'malignant social psychology' (Box 4).

Assessment of agitation
To help agitated people effectively, it is important to identify and address the root causes of their agitation, as well as the individual symptoms. The team should consider who should be involved to enable this to happen. The person and their family, providing the person is happy for them to be involved, would usually have an essential role in this process. Where dementia is suspected, the person should be referred to their local memory assessment service (NICE 2006) via either the GP or, for people in hospital, the mental health liaison service.

Differentiating delirium, dementia and depression
Differentiating delirium, dementia and depression from one another is not always straightforward because of their overlapping symptoms. However, some differences can be discerned (Table 1). Mental health professions can assist in the process of differentiating delirium, dementia and depression.

Life history
Taking a detailed life history from the person and his or her family can be helpful to provide context to behaviour. This may include their occupation before retirement, significant events, things they like or dislike, and things that make them frightened or angry.

In the case study for this article, Mary's husband informed staff that she had worked as a greengrocer, and later owned a sandwich shop business. They were informed that Mary found it difficult to socialise with others, outside of her main family. She enjoyed holidays, dancing, reading, watching soap operas on television, collecting dolls and building doll's houses.

Complete time out activity 2

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**BOX 4**

**Examples of damaging staff behaviours**

- Treachery – using forms of deception to distract or manipulate a person or force them into compliance.
- Disempowerment – not allowing a person to use their abilities or failing to help them to complete actions that have been initiated.
- Infantilisation – treating a person patronisingly (or `matronisingly`), as an insensitive parent might treat a young child.
- Intimidation – inducing fear in a person through the use of threats or physical power.
- Labelling – using a category such as dementia as the main basis for interacting with a person and for explaining their behaviour.
- Stigmatisation – treating a person as if they are a diseased object or an outcast.
- Outspicing – providing information or presenting choices at a rate too fast for the person to understand; putting them under pressure to do things more rapidly than they can bear.
- Invalidation – failing to acknowledge the subjective reality of a person's experience, especially what they are feeling.
- Banishment – sending a person away, or excluding them, physically or psychologically.

(Adapted from Kitwood 1997)

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52 march 25 : vol 29 no 30 : 2015

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NURSING STANDARD
**Tools**

Observational rating scales that measure behaviours are useful for understanding what is happening for people who struggle to communicate verbally or who are not aware of their own needs. The Cohen-Mansfield (1991) tool measures agitation. The Abbey et al (2004) pain scale is designed to detect pain in people with dementia who cannot express their pain verbally (Box 5). Antecedent-behaviour-consequence (ABC) charts can be useful in understanding triggers for behaviour. An example of an ABC chart, with details of how these may be used as part of a care pathway, is provided on the NHS Protect (2013b) website.

**Philosophy of care**

The principles of person-centred care underpin good practice in the care of people with dementia (NICE 2006). These include providing care that is designed around a person's needs and takes into account their preferences (NICE 2006). Other principles of person-centred care are valuing individuals, recognising their uniqueness, trying to understand the world from their perspective and supporting their psychological needs (Brooker 2007). The VIPS framework for person-centred care involves (Brooker 2007):

- **V** – A value base that asserts the value of all human lives, regardless of age or cognitive ability.
- **I** – An individualised approach, recognising uniqueness.
- **P** – Understanding the world from the perspective of the service user.
- **S** – Providing a social environment that supports psychological needs.

Care should always be provided in the least restrictive way possible according to the Mental Capacity Act 2005. This includes keeping one-to-one observation of patients under regular review to ensure that it does not continue for longer than necessary (NICE 2005) or become part of a culture of surveillance or containment (Schofield et al 2012). Family input is essential to understand the person and their life. Therefore it is important that family members have contact with staff and are involved in care planning and meetings, in accordance with the triangle of care philosophy (Royal College of Nursing 2013).

**TABLE 1**

<table>
<thead>
<tr>
<th>Differential symptoms of dementia, delirium and depression</th>
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<tbody>
<tr>
<td>Onset of symptoms</td>
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<tr>
<td>Level of anxiety</td>
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<tr>
<td>Mood</td>
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<tr>
<td>Thinking or attention</td>
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<tr>
<td>Performance on Mini Mental State Examination</td>
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<td>Memory</td>
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<tr>
<td>Consciousness</td>
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<tr>
<td>Hallucinations</td>
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<tr>
<td>Orientation to time and place</td>
</tr>
<tr>
<td>Suicidal thoughts</td>
</tr>
<tr>
<td>Panic or agitation</td>
</tr>
<tr>
<td>Time symptoms are worst</td>
</tr>
</tbody>
</table>

3. In the environment in which you work, consider the layout, lighting, signage, position of staff, high-traffic areas, restricted areas, exits and the location of beds, bedrooms and chairs. Mark on a plan of your ward the flash points where people are most likely to display agitated behaviour and/or aggression. Discuss with your colleagues and check incident reports, to see where disturbed or violent behaviour has occurred repeatedly.

4. Reflect on the flash points you identified in time out activity 3. Write down any aspects of the environment that you think could contribute towards disorientation, frustration or overstimulation of patients. Think about any locked doors with a visual appearance that might attract attention, and any toilet doors that are difficult to identify. Make a note of places that bring the person into close proximity or conflict with others. Share your findings with your line manager at your place of work or discuss them in a team meeting, and find some solutions together.
**CPD older people**

**BOX 5**
Ongoing assessment and management of Mary's pain

After initial assessment, it became clear that Mary was experiencing pain. She was unable to verbalise this, but staff came to this conclusion because of her body language. While Mary appeared to be grimacing in pain, she was holding her abdomen, calling out, flinching on movement, rubbing her face and pulling at her hair.

- Mary was referred to the palliative care team for expert advice on pain management.
- Her pain was monitored using the Abbey pain scale, looking for non-verbal indicators of pain, since Mary was unable to voice her pain.
- Mary was nursed in a calm and comfortable environment.
- She was assessed and had regular input from the physiotherapist, including massage when accepting of this.
- Mary was prescribed regular pain relief, since it was in her best interests to avoid breakthrough pain (Walter et al. 2008).

There was an obvious change in Mary's distress levels and behaviour after regular pain relief was commenced. Although she still spent time calling out, she was more relaxed in her presentation. She was no longer rubbing her face or pulling at her hair. Her appetite and mobility improved.

**BOX 6**
Reducing Mary's risk of agitation via modification of the environment

- Mary was able to recognise her room since it was colour-coded and had a distinctive picture on the door.
- The ward was in a loop or square shape, which enabled her to walk around the ward without encountering frustrating barriers.
- Mary's routine was kept consistent, as far as possible (Hoffman and Platt 2000).
- Natural lighting was used on the unit as much as possible.
- There was clear signage of areas she might be looking for, such as the lounge and the toilets.
- The clock and calendar were visible (NICE 2010).
- The bed was positioned for visibility and access to the bathroom: orienting symbols were used to identify the bathroom. Shades of red are most visible to the ageing lens (Silverstein and Flaherty 2012).

**BOX 7**
Adjusting the level of environmental stimulation according to patient need

**For overstimulation:**
- Play relaxing music at mealtimes (Goddard and Abraham 1994).
- Ensure the atmosphere is quiet, with minimal background noise and distractions.
- Ensure regular access to outside areas. Mary particularly enjoyed sitting in the sun relaxing.
- Reassure the person that they are in a safe place and belong there (Silverstein and Flaherty 2012).

**For understimulation:**
- Provide a sensory-rich environment (Hudson 2003).
- Encourage socialisation with other patients when calm.
- Provide cognitively stimulating activities such as reminiscence (NICE 2010).

**Remove triggers:**
- Do not stop the person walking; walk with them instead (Silverstein and Flaherty 2012) and ensure safe routes to do this (Barnes and Raskind 1980).
- Reduce triggers that encourage the person to want to leave by keeping stairs, lifts, exits, shoes, suitcases and busy areas out of the person's view (Silverstein and Flaherty 2012).
- Prevent intrusion of other patients into the person's personal space (Kvammen and Whitefield 2008).

**For an individualised space:**
- Provide comforting objects such as stuffed toys (Hoffman and Platt 2000) or objects from home (Dewing 2010).

**Environment**

Ideally, care of patients with dementia should be provided in small bespoke units but, where this is not possible, there are a number of design changes that can maximise orientation for patients with dementia (Cheston and Bender 1999). Environmental modification may be as simple as changing the colour of a door, yet have a dramatic and long-lasting effect. Colour schemes, floor coverings, assistive technology, signage and garden design are areas to consider (NICE 2006). Agitation may be reduced in many ways through environmental modification. These approaches include promoting orientation, avoiding sensory overload (overstimulation), avoiding boredom (understimulation), removing known triggers such as highly visible locked doors, and creating individualised space, where possible. Examples of environmental modifications to reduce Mary's agitation are given in Box 6.

Further examples of modifications to the environment that can be performed are provided in Box 7. Further information about how to develop dementia-friendly environments can be obtained from the University of Stirling website: [http://dementia.stir.ac.uk/design/virtual-environments](http://dementia.stir.ac.uk/design/virtual-environments)

**Prevention of agitation**

People who are at risk of delirium should be identified within 24 hours of admission to an acute hospital (NICE 2010). Unfamiliarity and change can increase the likelihood of agitation, so those who are identified as at high risk of delirium should receive care based on continuity and consistency (NICE 2010). Therefore, staff should be allocated to the patient they are familiar with and efforts should be made to avoid moving patients between wards and bays (NICE 2010).

Individual triggers for agitation should be well understood and the person's care should be planned around reducing their frequency and effect (Box 8). Personal care should be delivered in a way that minimises anxiety and promotes dignity, using as few staff as possible. Similarly, when carrying out a procedure that may cause the person pain or discomfort, such as changing wound dressings, consider giving pain relief beforehand. Take time to orient the
person first, and warn them immediately before any likely pain or discomfort. Continually monitor the person for signs of distress while you are assisting them. If the person becomes agitated, stop and reassure and explain what is happening. Seek consent again before restarting interventions. Box 9 illustrates how Mary was supported at mealtimes.

**Communication**

Building rapport with people prone to agitation is important, especially with those who may have underlying suspiciousness or paranoia and may find it difficult to trust people. A relaxed, open and friendly manner can help to foster trust, as can finding common ground such as pets, holidays, children or hobbies to discuss.

**Complete time out activity 3**

If a person confides that they believe others are trying to harm them, they should be reassured that they are in a safe place and staff will ensure that no harm will come to them. Non-verbal communication such as smiling, making eye contact, nodding when the person is speaking and leaning forward signifies interest in what they are saying.

Ensure that any aids the person usually uses are accessible, such as hearing aids, glasses, dentures, a stick or a frame, since without them the person may feel vulnerable or misinterpret situations if they cannot see or hear properly. When talking to people with cognitive impairment, avoid jargon, speak in clear short sentences and do not overload the person with information.

**Complete time out activity 5**

A description of how staff communicated with Mary is provided in Box 10. Staff should avoid using ‘malignant social psychology’ (Kitwood 1997) or ‘elderspeak’—talking to people with dementia in a way that appears patronising (Jenkins and Kay 2013). They should also beware ‘leaking signals’, body language which betrays hidden feelings such as irritation, since people with dementia seem to have heightened awareness of non-verbal signals (Killick and Jan 2001).

In potentially violent situations, it is helpful to have the skills to defuse difficult situations and the ability to calm people down de-escalation, where it is safe to do so. Verbal and non-verbal techniques can be used to de-escalate the situation (NICE 2005), including those listed in Box 11. These may need to be adapted, according to the needs of each person. Emphasis should be on tolerance, understanding and providing a safe and supportive environment, where restraint is only ever used as a last resort (NHS Protect 2013a).

**Complete time out activity 6**

**Treatment and therapies**

People with dementia (NICE 2006) and people with delirium (NICE 2010) should only receive pharmaceutical intervention as a first-line treatment if they are severely distressed or an immediate risk to themselves. Side effects of sedating medications include dizziness and unsteadiness, which can increase the risk of falls in older people. Antipsychotic medication may cause other problems such as movement disorders and hypersalivation, affecting the person’s quality of life. Antipsychotic medications can treble the risk of stroke in people with dementia and cause a range of other adverse effects that can put lives at risk.

**Avoiding agitation during personal care**

- Orient the person before you begin, explain who you are and why you are there.
- Use familiar staff wherever possible, who have good rapport with the person.
- Accommodate personal preferences, such as taking a bath rather than a shower, and offer choice.
- Provide reassurance and calming interaction throughout.
- Maintain dignity and respect.
- Do not rush; ensure time is taken with each step and that you are not going too fast for the person.
- Seek additional consent before touching or moving a part of the body that is painful, or attempting to wash any intimate areas.
- Stop if the person becomes distressed and reorient, reassure and seek consent before continuing.
- Offer assistance. If it is declined, re-approach once the person is calmer, using a different staff member if necessary.

(Waite et al 2008)

**BOX 9**

**Reducing Mary’s agitation at mealtimes**

Mary did not want to eat initially, so mealtimes were stressful for her. A care plan was designed to maximise her nutritional intake, balanced against reducing her agitation. This included:

- Protected mealtimes, ensuring no distractions.
- Providing her favourite foods.
- Her husband sitting with her at mealtimes.
- Working alongside her carer (husband) to identify personal preferences.
- Ensuring a calm environment.
- Approaching Mary with small amounts of food regularly.
- Giving her ‘finger foods’ that she could eat while walking.
- Providing her with specially adapted cutlery that was easier for her to hold and a cup with a spout that she could carry.
(All-Party Parliamentary Group on Dementia 2008), and were not designed for use in people with dementia or other frail older people with medical co-morbidities (Bangerjee 2009). Antipsychotic medications may also accelerate cognitive decline in people with dementia (Howard et al 2001), may be ineffective in treating agitation (Lonergan et al 2012) and may make agitation significantly worse (Talerico et al 2002). Banerjee (2009) found that antipsychotic medications were widely overprescribed to people with dementia by as much as two-thirds. Where they must be given, it is recommended that they are given in the least restrictive way, for example orally first (Jenkins and McKay 2013). Guidance for giving medications in the safest way to people with dementia is provided seen in Box 12 (NICE 2006).

NICE (2006) recommends five non-pharmacological therapies for treating agitation in people with dementia: aromatherapy, multisensory stimulation, therapeutic use of music and/or dancing, animal-assisted therapy and massage. These therapies seem to be particularly effective when given during or before an activity that might usually induce agitation. One study found that relaxing music played during mealtimes reduced agitation by 63% on the Cohen-Mansfield agitation Inventory in people with severe cognitive impairment who lived in nursing homes (Goddard and Abraham 1994). Another demonstrated a significant difference in agitation levels when hand massage was given before morning personal care (Snyder et al 1995). Multisensory stimulation is also recommended for agitation in people with dementia (NICE 2006). However, there is insufficient evidence of the efficacy of Snoezelen (a controlled multisensory environment) in people with dementia (Chung et al 2002). One of the reasons stronger effects are not evident in other studies may be that responses to therapy are highly individual, and depend on tastes and preferences. Therapies used with Mary are outlined in Box 13.

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**BOX 10**

**Communicating with Mary**

Mary’s ability to communicate was affected by her cognitive impairment and she was unable to explain to the nursing staff the reasons for her distress. All of Mary’s needs had to be anticipated by the nursing staff, using body language and other non-verbal communication as a guide. The environment was also important to aid communication, requiring a relaxing space with less distractions and noise. To meet Mary’s needs, nursing staff ensured the following when communicating with her:

- Staff spoke clearly and calmly, avoiding assertive tone and language.
- Attempts were made with alternative communication, such as picture cards.
- Staff used hand massage during distressing periods, to calm and reassure Mary.
- Staff reduced background noise and distractions.
- Short sentences and different ways of saying the same thing were used.
- Staff used gestures and body language.

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**BOX 11**

**De-escalation techniques**

Ask for facts about the problem and encourage reasoning:
- Attempt to establish rapport and emphasise co-operation.
- Offer and negotiate realistic options and avoid threats.
- Ask open questions and enquire about the reason for the person’s anger, for example ‘What has caused you to feel upset or angry?’
- Show concern and attentiveness through non-verbal and verbal responses.
- Listen carefully and show empathy, acknowledge any grievances, concerns or frustrations, and do not be patronising or minimise concerns.

Ensure your non-verbal communication is non-threatening and not provocative:
- Pay attention to non-verbal cues, such as eye contact, and allow greater body space than usual.
- Adopt a non-threatening but safe posture.
- Appear calm, self-controlled and confident without being dismissive or overbearing.

(National Institute for Health and Care Excellence 2005)

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**BOX 12**

**Minimising risk when using antipsychotic medication**

Summary of principles for use:
- Discuss the benefits and risks of treatment with the person with dementia if appropriate, or their next of kin and team.
- Identify target symptoms.
- Commence administration at low dose initially and then titrate upwards.
- Monitor effect on cognition and review target symptoms.
- Limit treatment time.
- Offer oral medication first.
- Use intramuscular rather than intravenous administration where possible.
- Monitor vital signs after injection.
- Staff should receive training on resuscitation and physical monitoring of health.

(National Institute for Health and Care Excellence 2006)
**Conclusion**

Reducing agitation in older people should begin with empathising with the person and trying to understand their reality. Being curious and involving significant others helps staff to understand the person better and makes identifying the causes of their agitation easier. Staff can ensure that the person receives care that is tailored to their needs by following person-centred principles. This article has described potential strategies for reducing agitation in an older person. In practice, finding a successful strategy often requires trial and error. Staff should not feel discouraged if multiple unsuccessful attempts are required before a strategy is found which succeeds for the person. Identifying a successful strategy for minimising agitation in an older person has the potential to improve that person's life.

Complete time out activity;

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**BOX 13**

**Therapeutic approaches used with Mary**

Occupational therapy played a vital role in the assessment of Mary's activity levels and in formulating a plan of care with nursing staff to use distraction techniques with her during periods of distress. It was difficult for staff to engage Mary in any activity that required high levels of concentration or understanding, because of her high levels of distress and level of cognitive impairment.

Staff worked closely with Mary's husband to complete her life story, and to learn her likes or dislikes. Mary was assessed using the Pool Activity Level (PAL) Checklist (Pool 2012) to establish the level in which she was functioning: planned, exploratory, sensory or reflex. On admission, Mary was functioning at a more reflex level; however, as she began to settle in, her mood and mental state altered and she was able to function at a more sensory level.

Staff tailored activities to Mary's specific likes and activity level and created an 'activity profile' for staff to use during periods of distress or on a daily basis. Mary enjoyed activities such as hand massage, the sensory room, music, smelling salts and others reading to her. Staff were able to use these during periods of distress, which helped to calm her. Staff also worked with Mary's husband to produce a 'self-soother' box which contained items that she recognised and enjoyed.

With a multidisciplinary approach, staff were able to manage Mary's level of agitation and distress, resulting in a better quality of life for Mary post-discharge.

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**References**


How to increase physical activity in demented patients.


