Recognizing and Managing Agitation in Dementia

Early Warning Signs and De-Escalation Strategies

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Learning Objectives

By the end of this 60-minute session, participants will be able to apply evidence-based strategies directly at the bedside. These objectives are designed to be immediately actionable for nurses, therapists, and case managers working in memory care and post-acute settings.

What You Will Learn Today

1

Identify Early Warning Signs

Recognize the behavioral, verbal, and physiological cues that signal escalating agitation before a crisis occurs.

2

Apply Non-Pharmacologic Strategies

Implement structured de-escalation and environmental modification techniques grounded in person-centered care.

3

Differentiate Agitation from Other Causes

Distinguish agitation from delirium, undertreated pain, and psychiatric etiologies to guide appropriate clinical response.

How This Session Is Structured

This CE activity is organized to build knowledge progressively — from understanding the neurobiology of agitation, to real-world recognition, assessment, and practical management. Case scenarios and self-reflection questions are embedded throughout.

How This Session Is Structured

1. **Foundation**	What agitation is, why it happens, and the brain science behind it
2. **Recognition**	Early warning signs, triggers, and assessment frameworks
3. **Response**	Non-pharmacologic and pharmacologic management strategies
4. **Escalation**	When and how to escalate, and regulatory/safety considerations
5. **Reflection**	Self-assessment, key takeaways, and evidence-based practice summary

Why This Matters

Agitation Is One of the Most Common — and Challenging — Symptoms in Dementia

- Up to **90% of individuals with dementia** will experience behavioral and psychological symptoms at some point. Agitation is consistently cited as the most disruptive and the most difficult to manage. It affects patients, families, and the entire care team.



The Ripple Effect on Staff, Systems, and Safety

Hospitalizations

Behavioral crises are a leading driver of emergency transfers and avoidable hospitalizations in memory care and SNF settings.

Burnout

Unmanaged behavioral episodes are a top contributor to caregiver burnout and staff turnover in post-acute settings nationwide.

Staff Injuries

CNAs and nurses face a disproportionately high rate of workplace injuries – particularly during personal care tasks – when agitation is not recognized early.

Cost Impact

The annual cost of dementia-related behavioral complications — including hospitalizations and staffing **— exceeds $9 billion** in the U.S. alone.

Quality of Care Is Directly at Stake

When agitation is poorly managed, residents experience **greater physical restraint use, higher rates of chemical sedation, and reduced quality of life**. Facility survey deficiencies related to behavioral management remain among the most common CMS citations in long-term care.

Person-centered care and early intervention aren't just the right approach – they are increasingly the **regulatory and reimbursement expectation**.

Quality of Care Is Directly at Stake

- **The Stakes**
  - Reduced resident dignity and autonomy
  - Increased restraint and sedation use
  - CMS deficiency citations
  - Lower star ratings and reimbursement risk
  - Staff turnover and recruitment challenges

Quality Indicator

Facilities with structured behavioral management programs show measurably lower antipsychotic use, fewer falls, and improved survey outcomes.

What Is Agitation?

Defining Agitation in the Context of Dementia

Agitation is not simply “bad behavior.” It is a clinical syndrome characterized by **inappropriate verbal, vocal, or motor activity** that is not explained by apparent needs or confusion alone. The International Psychogeriatric Association (IPA) defines it as occurring in the context of cognitive impairment with evidence of distress.

Defining Agitation in the Context of Dementia

Core Features

Excessive motor activity, verbal aggression, or physical aggression — occurring more frequently than is appropriate given the clinical context.

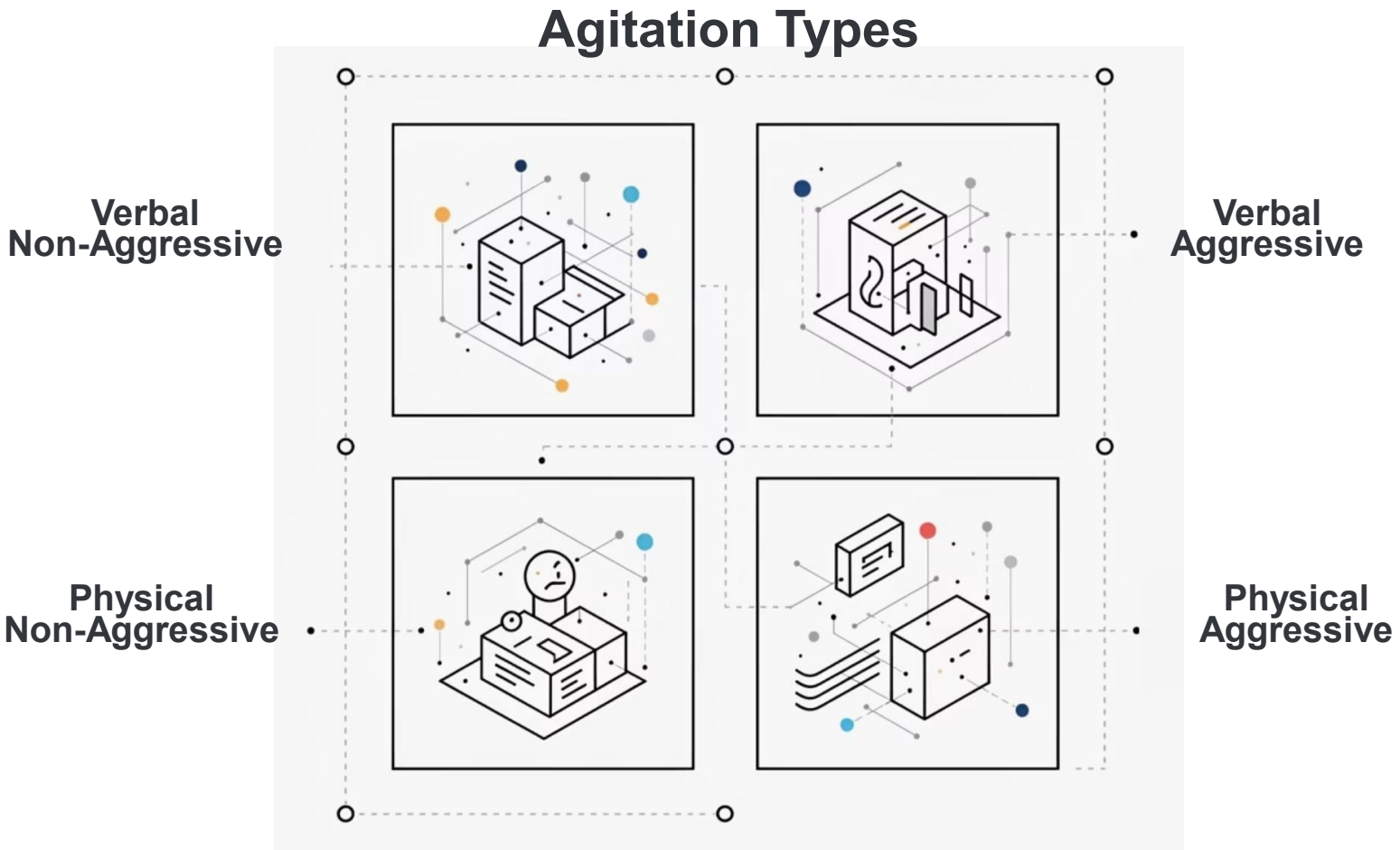
Not Willful

Agitation is a neurobiological response, not intentional defiance. The person cannot "choose" to stop — they need support, not correction.

Always Communicates Something

Agitation is the patient's way of signaling an unmet need — physical, emotional, or environmental. Your job is to decode that signal.

Types of Agitation: A Clinical Taxonomy



Understanding the **type** of agitation guides the most appropriate intervention.

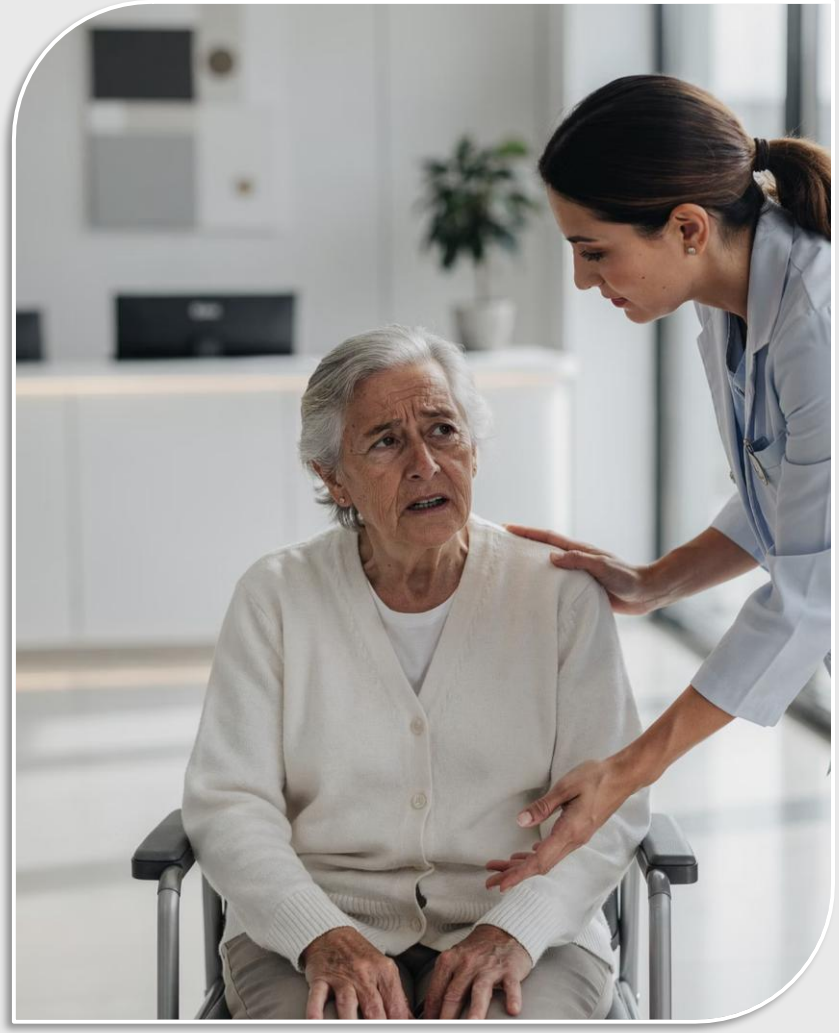
Physical non-aggressive behaviors often respond to environmental modifications; verbal aggressive behaviors often signal emotional distress requiring validation and connection.

Agitation as Unmet Need: The Communication Model

- The **Unmet Needs Model** (Algase et al.) frames agitation not as a symptom to suppress, but as a form of communication. When verbal and cognitive capacity diminish, behavior becomes the primary language. Every episode carries a message — pain, fear, loneliness, discomfort, or confusion.

Clinical Pearl

Before reaching for the phone to call the physician, ask: “What is this person trying to tell me?” Identifying the unmet need is the first and most powerful intervention.



Neurobiology

The Brain Behind the Behavior

- **Frontal Lobe Dysfunction**
  - Dementia progressively damages the **prefrontal cortex**, which governs impulse control, emotional regulation, and judgment. As this region deteriorates, the brain loses its ability to modulate distressing stimuli — leading to disproportionate emotional and behavioral reactions.

- **Limbic System Dysregulation**
  - The amygdala — the brain's alarm center — becomes hyperactive as dementia advances. Patients experience fear and threat responses to ordinary stimuli: a caregiver's approach, a change in routine, or an unfamiliar environment.

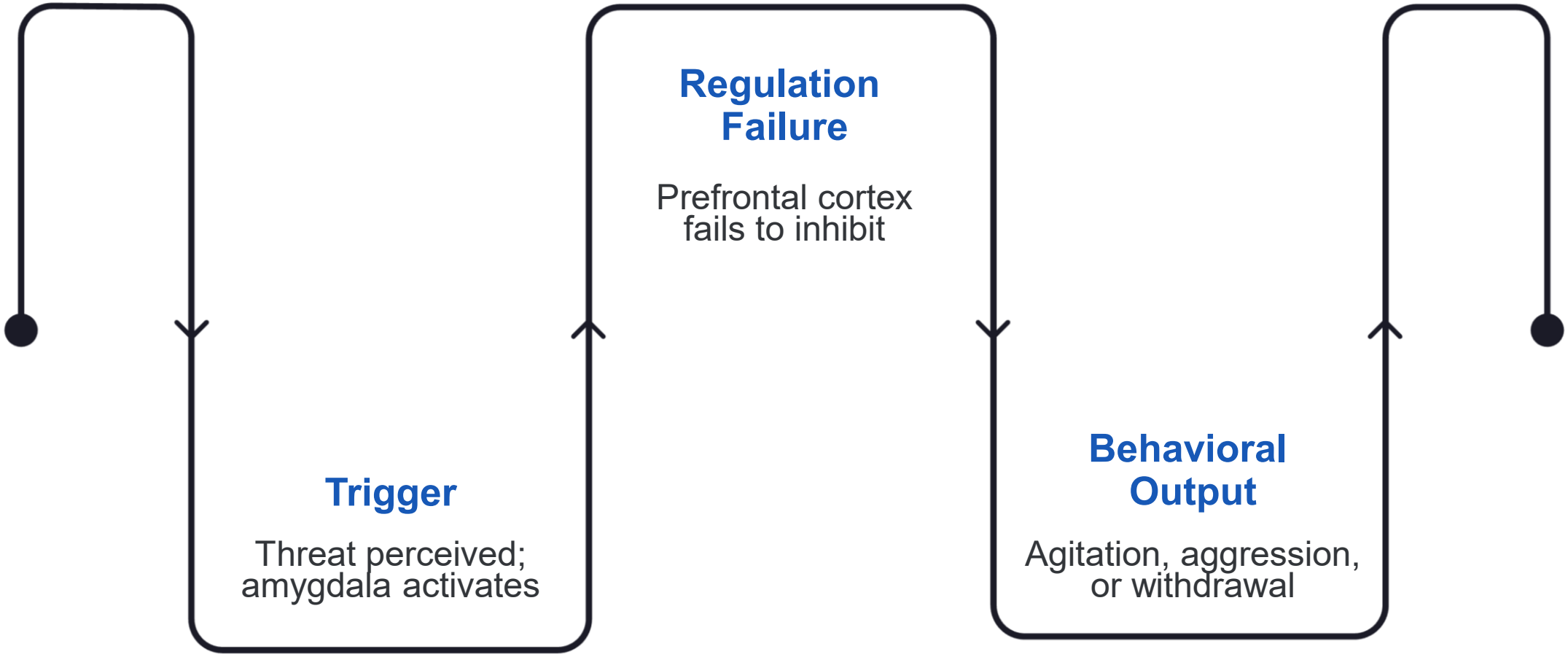
The Brain Behind the Behavior

- **Neurotransmitter Imbalance**
  - **Serotonin deficits** — mood dysregulation, anxiety, aggression
  - **Dopamine dysregulation** — psychosis, agitation, motor restlessness
  - **Cholinergic loss** — confusion, attention deficits, behavioral fluctuation
  - **Norepinephrine excess** — hyperarousal and combativeness

Why This Matters Clinically

Understanding the neurochemical basis helps explain why pharmacologic interventions alone are often insufficient — and why sensory and environmental approaches can be so effective.

What Happens in the Brain During an Episode



This stress-response cascade **is involuntary and neurologically driven**. Staff who understand the brain science behind agitation are better equipped to respond with patience, structure, and targeted interventions rather than reactive escalation.

Why Dementia Type Matters for Behavior

- **Alzheimer's Disease**
  - Late-stage agitation; often linked to fear, confusion, and sundowning. Responds well to routine, familiar stimuli, and calm reassurance.

- **Frontotemporal Dementia**
  - Early and severe behavioral disinhibition due to frontal lobe atrophy. Impulse-control deficits are prominent; standard dementia approaches may need adjustment.

Why Dementia Type Matters for Behavior

- **Lewy Body Dementia**
  - Vivid hallucinations and fluctuating cognition drive agitation. Antipsychotics are contraindicated and can be life-threatening.

- **Vascular Dementia**
  - Stepwise decline with variable behavioral symptoms; anxiety and emotional lability are common. Cardiovascular risk management is essential.

Common Triggers

Triggers: Where Agitation Begins

- Agitation rarely appears without cause. Identifying and addressing the underlying trigger is the single most effective intervention. Triggers fall into four major categories — and multiple triggers often co-occur.

- When a person with dementia cannot verbalize pain or discomfort, the body speaks through behavior. **Always rule out a medical cause first** — especially in patients with a sudden change in behavior.



Medical Triggers: The Body in Distress

- **Pain**
  - Arthritis, pressure wounds, dental pain, fractures, and post-procedural discomfort are frequently missed.



- **Constipation/Urinary Retention**
  - Impaction and urinary retention cause significant physical distress. Review bowel records, assess abdomen, and check bladder scan results.



Medical Triggers: The Body in Distress

- **Infection**
  - UTIs, pneumonia, and skin infections often present as behavioral change rather than classic fever/chills in older adults with dementia. Check vitals and urinalysis.



- **Medication Side Effects**
  - Anticholinergics, steroids, opioids, and polypharmacy can all provoke or worsen agitation. Review the MAR with the pharmacist or provider.



Common Triggers – Environmental

Environmental Triggers: Sensory Overload and Disorientation

- **Overstimulating Environments**
  - Loud televisions or intercom announcements
  - Multiple conversations happening simultaneously
  - Bright, flickering, or fluorescent overhead lighting
  - Busy, crowded common areas during peak activity

- **Physical Environment Cues**
  - Unfamiliar rooms or recent room changes
  - Clutter or disorganized personal space
  - Temperature extremes — too hot or too cold

Environmental Triggers: Sensory Overload and Disorientation

- **What You Can Do**
  - Environmental modifications are among the most evidence-supported, lowest-risk interventions available. Small changes yield measurable results:
    - Dim lights and reduce background noise in the late afternoon
    - Create consistent, familiar spaces with personal items
    - Minimize the number of people in the room during care
    - Use soft music or nature sounds to buffer ambient noise

Tip

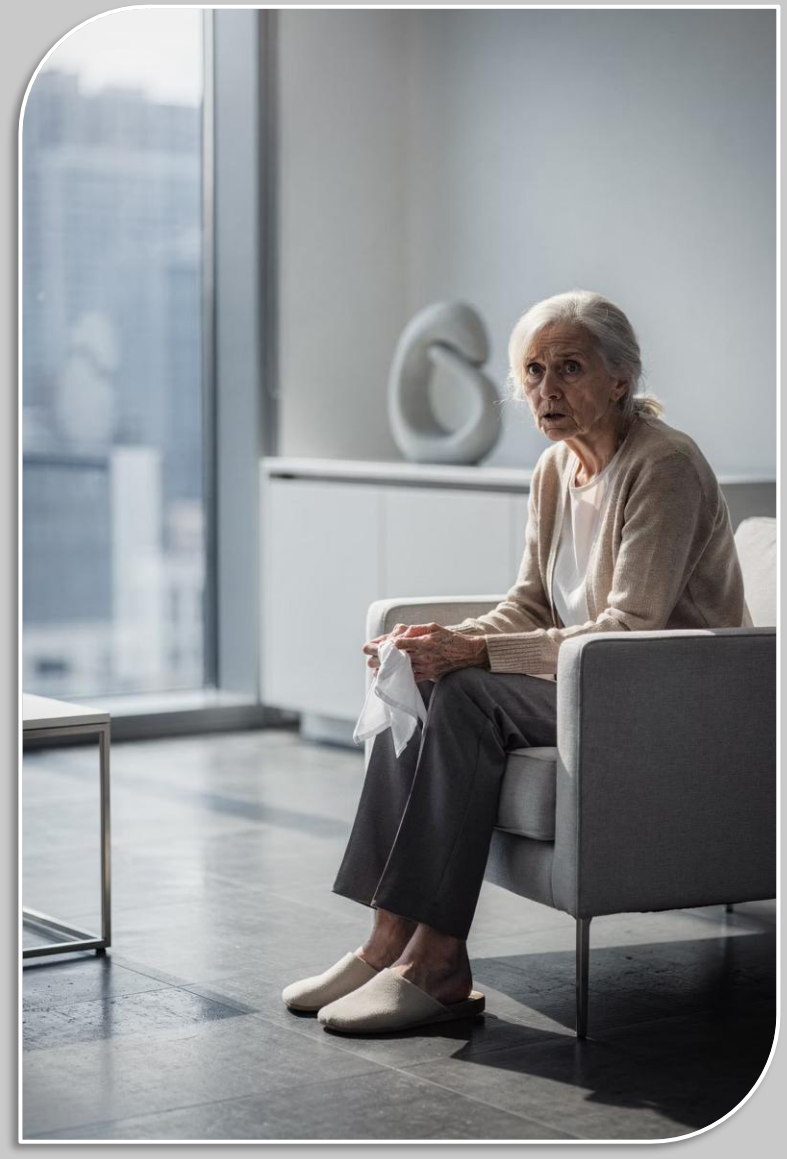
Walk the unit through the eyes of someone who is confused and fearful. What would feel threatening or overwhelming to them?

Common Triggers – Phycological

Psychological Triggers: Fear, Loss, and Confusion

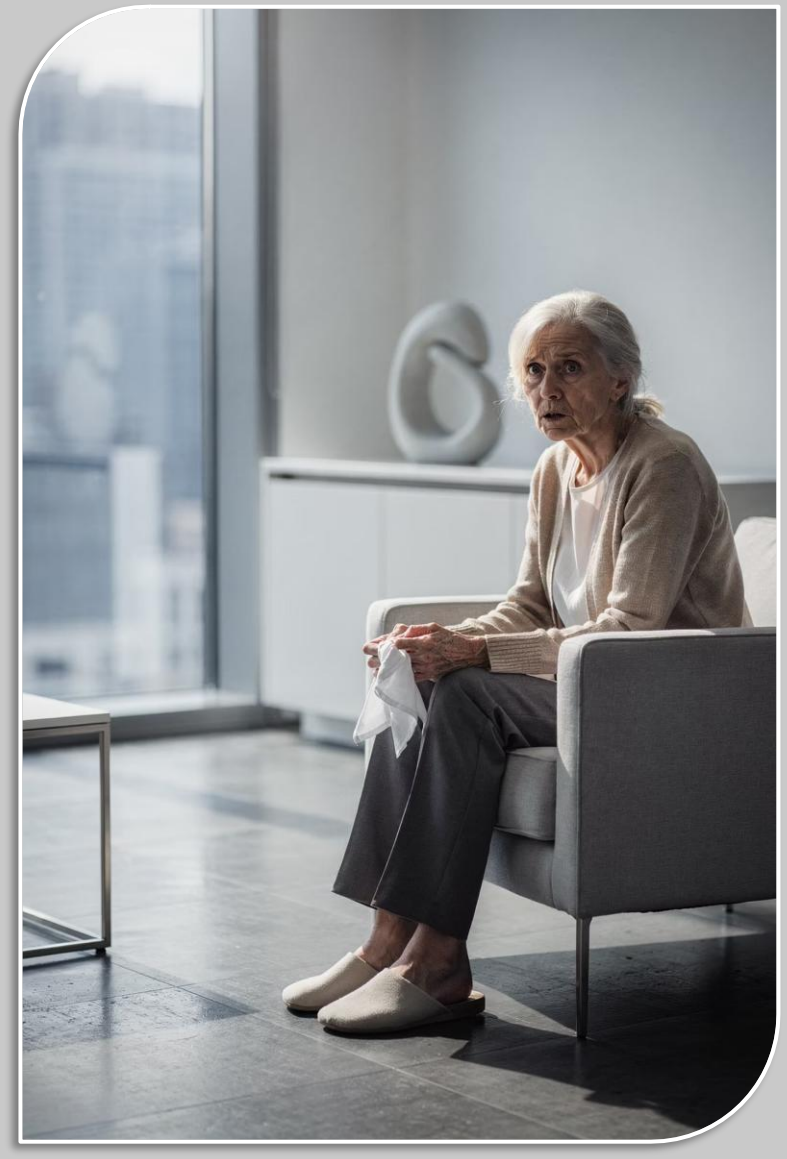
- **Fear and Perceived Threat**
  - Misidentifying caregivers as strangers, believing they are in a dangerous place, or experiencing paranoid ideation can all provoke defensive aggression.

- **Grief and Loss**
  - Patients may experience acute grief over losses they repeatedly re-discover — the death of a spouse, separation from family, or losing the ability to go home.



Psychological Triggers: Fear, Loss, and Confusion

- **Loss of Control and Autonomy**
  - Dementia strips away independence. Forced compliance during care routines without offering choices or explanations frequently triggers resistance and agitation.



Common Triggers – Care-Related

Care-Related Triggers: The Most Preventable Category

Many agitation episodes are directly precipitated **by how care is delivered,** not just the care itself. The approach, pace, and communication style of the caregiver matter enormously

Care-Related Triggers: The Most Preventable Category

- **Bathing and Dressing**
  - These are the highest-risk personal care tasks. Undressing feels exposing and threatening. Cold water, sudden touch, and lack of privacy trigger defensive responses.

- **Multiple Caregivers / Inconsistency**
  - Frequent staff changes, lack of consistent assignment, and unfamiliar faces are significant stressors for patients with dementia who depend on familiarity and predictability.

Care-Related Triggers: The Most Preventable Category

- **Rushed Interactions**
  - Moving too quickly through care tasks, not allowing processing time, or expressing frustration nonverbally — patients read these cues even when they can't articulate them.

- **Startling or Sudden Approach**
  - Approaching from behind, raising your voice, or initiating touch without verbal preparation can trigger an acute startle response that rapidly escalates to aggression.

Interactive Self-Assessment #1

Reflect and Respond

Think about the last time you witnessed or were involved in an agitation episode at your facility. Answer honestly — this is for your own learning.

Question 1

Looking back, can you identify a trigger that preceded the episode — medical, environmental, psychological, or care-related?

These questions will resurface throughout the session — keep your answers in mind as we build skills together.

Question 2

Was there a moment when you noticed early signs of distress before full escalation? What did those signs look like?

These questions will resurface throughout the session — keep your answers in mind as we build skills together.

Question 3

In hindsight, what is one thing that could have been done differently to prevent or de-escalate the episode earlier?

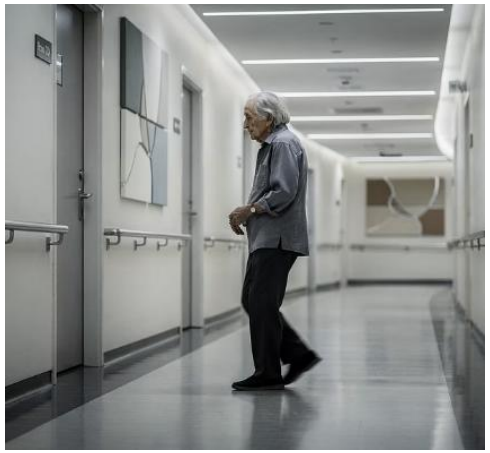
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Early Warning Signs

HIGH-YIELD: Catching Agitation Before It Escalates

The window between early warning and full escalation is your **most powerful intervention point**. Early recognition reduces crisis frequency, improves safety, and dramatically expands your management options. Most escalations are preceded by identifiable warning signals — if you know what to look for.

Motor and Behavioral Warning Signs



Pacing and Restlessness

Increased motor activity, inability to sit still, repetitive movement patterns. Often begins subtly — watch for a person who was calm but is now walking loops or shifting in their chair.



Repetitive Movements/Fidgeting

Wringing hands, picking at clothing, rubbing arms or face. Repetitive motor behaviors are a strong early signal of internal distress that has not yet become verbal or aggressive.



Facial Tension and Body Language

Furrowed brow, jaw clenching, tightened shoulders, or a fixed stare. The face often signals distress before vocalization begins. Train your eye to read these cues.

Verbal and Cognitive Warning Signs

- **Repetitive Questioning**
  - “When am I going home?” “Where is my husband?” — asked five times in five minutes. Repetitive questioning is not just a memory symptom; it is frequently an anxiety signal. The question may represent an emotional need more than an informational one.

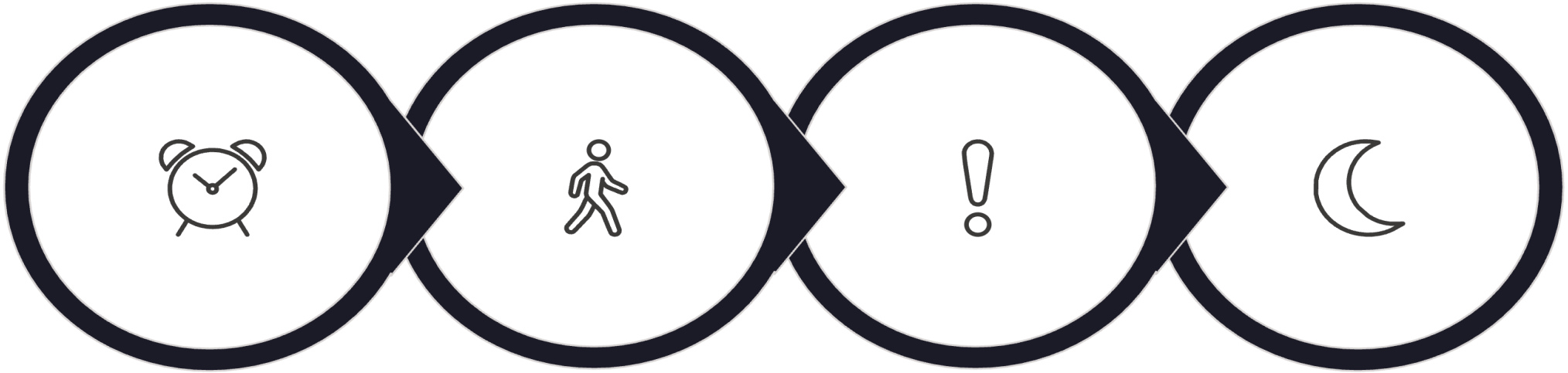
- **Increased Confusion or Disorientation**
  - A sudden worsening of baseline cognitive function — appearing more lost, glazed, or unable to track conversation. Always consider whether this represents **delirium superimposed on dementia**, which is a medical emergency.

Verbal and Cognitive Warning Signs

- **Tone and Volume Changes**
  - Voice becomes louder, sharper, or takes on a quality of urgency or fear. Watch for a shift from cooperative engagement to monosyllabic, clipped responses — often the precursor to verbal refusal.

- **Sleep Pattern Disruption**
  - Night-time awakening, increased daytime sleeping, or sundowning behaviors (worsening confusion in late afternoon/evening) are strongly predictive of escalation risk. Document and report changes in sleep-wake cycles.

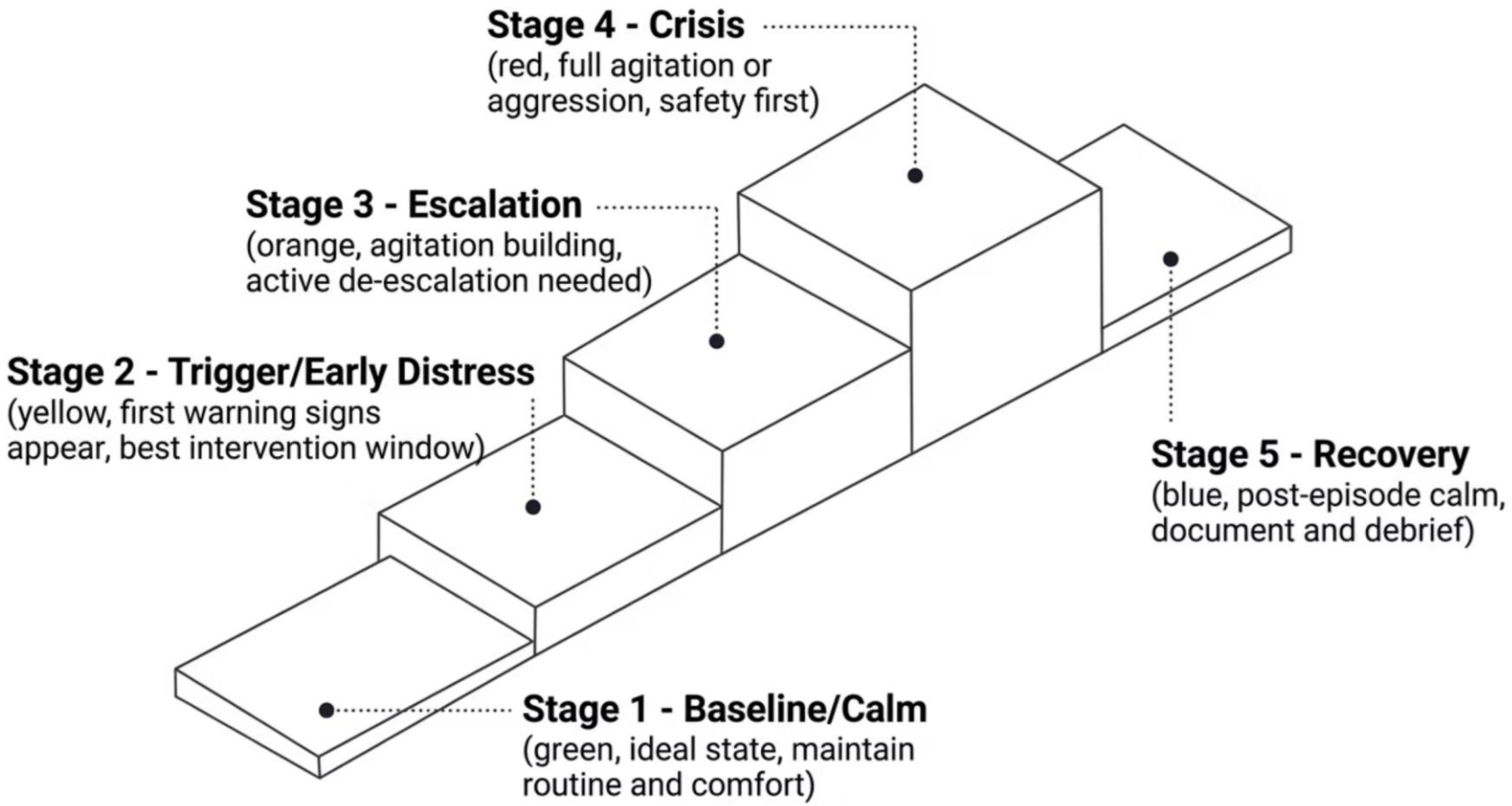
Sundowning: A Critical Pattern to Recognize



Afternoon Onset | **Early Evening** | **Evening Escalation** | **Night Disturbance**

Sundowning affects an estimated **20–45% of individuals with dementia**. It is not a separate disease but a predictable pattern of late-day behavioral escalation. Anticipating and proactively managing this window — with structured activities, reduced stimulation, and familiar routines — is one of the most effective preventive strategies available.

The Escalation Curve: Your Intervention Timeline



The earlier you intervene on this curve, the fewer resources you need and the better the outcome. **Stage 2 interventions** — catching the early warning — are 3–5 times more effective than Stage 4 crisis response. Build this pattern recognition into every patient interaction.

Assessment Framework

A Structured Approach to Assessment

- When agitation occurs or worsens, **a systematic assessment** prevents reactive management and ensures you're treating the cause, not just the symptom. The following framework applies whether you're a nurse, OT, PT, or case manager — everyone on the team plays a role.



Step 1: Rule Out Delirium First

- **Why This Is Critical**
  - Delirium is a **medical emergency** that is frequently mistaken for behavioral agitation in dementia. Missing delirium means missing the underlying medical cause — with potentially life-threatening consequences.

- **Use the CAM Tool**
  - The Confusion Assessment Method (CAM) identifies four features: acute onset with fluctuating course, inattention, disorganized thinking, and altered level of consciousness. Positive CAM = presumed delirium until proven otherwise.

Step 1: Rule Out Delirium First

- **Delirium vs. Agitation in Dementia**
  - **Onset:** Delirium = acute (hours/days); Dementia agitation = gradual or triggered
  - **Attention:** Delirium = severely impaired; Dementia = may be preserved
  - **Fluctuation**: Delirium = prominent within same day
  - **Cause:** Delirium = always has underlying medical etiology

Rule

Any sudden change in behavior = delirium workup first.

Step 2: Assess for Pain and Medical Triggers

1. **Pain Screening**
   - Use **PAINAD** (Pain Assessment in Advanced Dementia) or **Abbey Pain Scale** for nonverbal patients. Score breathing, negative vocalization, facial expression, body language, and consolability.

2. **Vital Signs and Labs**
   - Check temperature, oxygen saturation, blood pressure, blood glucose. Order urinalysis. Review recent labs for metabolic disturbances — hyponatremia, hyperglycemia, and hypoxia are common behavioral triggers.

Step 2: Assess for Pain and Medical Triggers *(continued)*

3. **Bowel and Bladder**
   - Review the last documented bowel movement and offer toileting. Perform a bladder scan if urinary retention is suspected. These are simple interventions with high yield.

4. **Medication Review**
   - Review the MAR for recent additions, dose changes, missed doses, or known agitation-inducing agents. Flag for pharmacist or provider review if indicated.

Step 3: Establish Behavioral Baseline and Patterns

Effective behavioral management requires knowing what is **typical for this individual** — not just what dementia looks like generically. Personalized baselines improve detection, communication, and care planning

Step 3: Establish Behavioral Baseline and Patterns

- **Cognitive Baseline**
  - What is this person's usual level of orientation, communication, and functional ability? Changes from that baseline — not from a textbook norm — are clinically meaningful.

- **Behavioral Pattern Recognition**
  - When does agitation typically occur? Time of day, care tasks, specific environments, or after particular interactions? Document and share patterns across the care team.

- **Communication Profile**
  - What verbal and nonverbal communication does this person use when distressed? What language do they respond best to? What brings comfort? This should be in every care plan.

Validated Tools for Behavioral Assessment

Tool	What It Measures	Best Used By
Cohen-Mansfield Agitation Inventory (CMAI)	Frequency of 29 agitation behaviors across verbal/physical domains	Nursing, charge nurse, behavioral health
PADINAD	Pain in nonverbal patients; 5-item observational scale	All bedside staff, nursing
CAM	Delirium screening; 4-feature algorithm	Nursing, advanced practice
Pittsburgh Agitation Scale (PAS)	Agitation severity in acute settings; 0–35 scale	Nursing, acute/post-acute staff
NPI-NH	Neuropsychiatric symptoms including agitation, anxiety, and psychosis	Behavioral health, social work, nursing

Evidence-Based Practice

Standardized tool use improves communication between team members, supports documentation for regulatory purposes, and enables tracking of intervention effectiveness over time.

Case Study: Mr. R.

- **Mr. R.** is an 82-year-old male with moderate Alzheimer's disease residing in a memory care unit. He was pleasant and cooperative at lunch but has become increasingly agitated since 4 PM. He is now pacing the hallway, refusing to go to his room, calling out “Help me! Help me!” repeatedly, and swatted at a CNA who tried to redirect him to dinner.
- He has a history of osteoarthritis and a UTI treated 3 weeks ago. His last documented bowel movement was 2 days ago. The evening shift has three new float staff he has never met.

For the Audience – Discuss

What are the most likely triggers in this scenario? What is your **first** clinical action? What non-pharmacologic interventions would you try and in what order?

Case Debrief: Applying the Framework

- **Likely Triggers Identified**
  - Sundowning (late afternoon onset)
  - Possible constipation (2-day absence of BM)
  - Unfamiliar staff (3 float staff on evening shift)
  - Possible recurrent UTI (behavioral change)
  - Environmental: transition to dinner, overstimulating common area

This case illustrates how multiple co-occurring triggers are the rule, not the exception.
A checklist approach to assessment prevents missing the treatable cause.

Case Debrief: Applying the Framework

- **Priority Actions**
  - Assign most familiar staff member to approach Mr. R.
  - Rule out delirium (CAM) and assess pain (PAINAD)
  - Offer toileting; check for urinary symptoms; notify provider
  - Reduce environmental stimulation — move to quieter area
  - Validate emotion: “You seem upset — I want to help you.”
  - Offer familiar comfort item or preferred music

This case illustrates how multiple co-occurring triggers are the rule, not the exception.
A checklist approach to assessment prevents missing the treatable cause.

Non-Pharmacologic Management

The Core of Dementia Behavioral Care

- Non-pharmacologic interventions are **first-line, evidence-based, and should always precede medication** unless there is an immediate safety risk. They are more effective, carry no adverse drug effects, and align with the person-centered values that define quality dementia care.



Communication Techniques That Work

- **Match Tone, Not Just Words**
  - Use a calm, low, unhurried voice. Dementia patients retain the ability to read **emotional tone** long after language comprehension fades. How you say it matters more than what you say.

- **Use Simple, Short Sentences**
  - One idea at a time. Allow 10–15 seconds for processing before repeating or moving on. Avoid asking multiple questions in sequence — offer simple choices instead of open-ended queries.

Communication Techniques That Work

- **Approach from the Front at Eye Level**
  - Never approach from behind. Crouch or sit to match eye level. Introduce yourself each time: “Hi, I'm Maria — I'm here to help you.” Give the brain time to process the approach before initiating touch.

- **Validate — Do Not Correct**
  - “You miss your husband — that makes sense.” Do not argue with their reality. Correcting false beliefs (“He died 10 years ago”) causes grief, fear, and escalation without therapeutic benefit.

Environmental Modifications

- **Reduce Stimulation**
  - Turn off the TV or radio during agitation episodes
  - Close room doors to reduce corridor noise
  - Dim overhead lights — use lamps or natural light
  - Limit the number of people in the room to 1–2

- **Create Familiar, Safe Spaces**
  - Personal photos, meaningful objects, familiar scents
  - Consistent room setup — don't rearrange furniture
  - Use the patient's preferred name and terms of address

Environmental Modifications

- **Scheduled Lighting and Activity**
  - Bright light therapy in the morning can help regulate circadian rhythms and reduce sundowning. Structured afternoon activity — especially before the 3–5 PM window — can prevent the escalation phase entirely.

- **Safe Wandering Pathways**
  - For patients who pace, designated safe walking loops with familiar landmarks and seating reduce falls and frustration while honoring the neurological drive to move.

Evidence-Based Practice

Environmental modification reduces agitation frequency by up to 40% in controlled studies when implemented consistently (Cohen-Mansfield, 2013).

The Power of Routine and Predictability

For individuals with dementia, **routine is safety**. When the brain can no longer construct new memories or predict what comes next, a consistent, predictable schedule provides a neurological anchor that reduces anxiety and behavioral reactivity.

The Power of Routine and Predictability

- **Consistent Assignment**
  - The same caregiver for the same resident, whenever operationally possible. Familiarity reduces the threat response and builds trust that lasts even when episodic memory does not.

- **Predictable Daily Structure**
  - Same wake time, mealtimes, bathing times. Use bridging language: “After breakfast, we'll get dressed together.” This reduces anticipatory anxiety significantly.

- **Pre-Care Preparation**
  - Announce activities before beginning. Lay out items so the patient can see what's happening. “I'm going to wash your face now” removes the element of surprise that often triggers resistance.

Redirection and Distraction Techniques

- **What Redirection Is — and Isn't**
  - Redirection is not dismissing the person's distress. It is acknowledging the emotion, then gently guiding attention toward something engaging or comforting. Acknowledge first, redirect second.

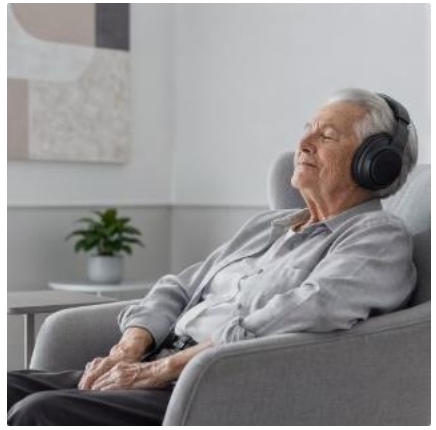
- **Purposeful Activities**
  - Folding towels, sorting objects, simple repetitive tasks — these provide sensory input and a sense of accomplishment. Match the activity to the person's historical interests and retained abilities.

Redirection and Distraction Techniques

- **Tap Into Long-Term Memory**
  - Ask about family, past career, or favorite places. Long-term autobiographical memory is often preserved longer than short-term memory. Connecting to the past calms the present.

- **Humor and Connection**
  - When appropriate and patient-specific, gentle humor and warmth can shift the emotional tone rapidly. Genuine human connection is one of the most powerful de-escalation tools available to any caregiver.

Sensory-Based Approaches



Music Therapy

Music activates brain regions largely spared by Alzheimer's disease. Personalized playlists — especially music from ages 10–25 — can reduce agitation by up to 60%. Implement before and during care tasks.



Therapeutic Touch

Hand massage, gentle stroking of the arm, or holding hands can reduce cortisol and activate the parasympathetic nervous system. Always obtain assent before initiating touch — watch for body language cues.



Familiar Objects and Scent

A familiar scent (lavender, a spouse's cologne), a cherished photo, or a meaningful object from the person's past can activate calming autobiographical memories and reduce acute distress rapidly.

Specialized Approaches Worth Knowing

- **Validation Therapy (Feil, 1993)**
  - Developed by Naomi Feil, this approach meets patients in their emotional reality rather than correcting it. Rather than orienting a patient to the present, you validate the emotional truth of their experience. Research supports reductions in agitation and improved staff-patient relationships.

- **Simulated Presence Therapy**
  - Recorded family voice messages played during agitation episodes can reduce distress, particularly during sundowning or nighttime. Families can record personalized audio clips that caregivers deploy as needed.

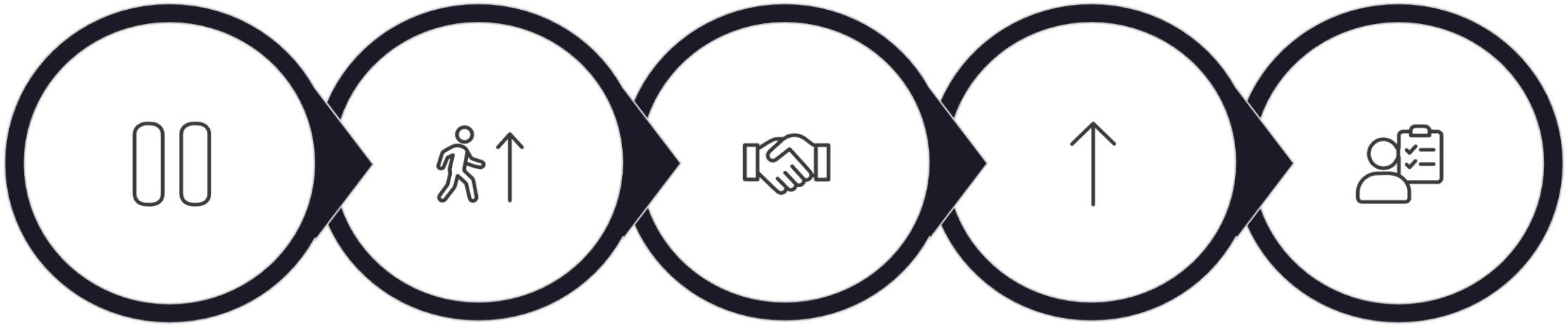
Specialized Approaches Worth Knowing

- **Snoezelen/Multisensory Environments**
  - Purpose-built sensory rooms with controlled light, sound, texture, and scent have shown significant benefit for reducing agitation frequency and duration in memory care settings. Portable multisensory elements can bring similar benefits to the patient's room.

- **Pet-Assisted Therapy**
  - Animal-assisted interventions have demonstrated reductions in agitation, loneliness, and depression in dementia populations. Facility-based pet programs or certified therapy animal visits are a practical, evidence-supported option.

De-Escalation Techniques

Step-by-Step De-Escalation: The PAUSE Framework



PAUSE **APPROACH** **VALIDATE** **REDIRECT** **EVALUATE**

This structured framework can be taught to all staff levels — from CNAs to RNs to therapists. Consistency in approach across the entire team produces far better outcomes than individual staff improvising different responses.

What NOT to Do: Common Mistakes That Escalate

- **Arguing or Correcting**
  - “That's not true — your husband passed away.” Correcting false beliefs causes acute grief and fear without any therapeutic benefit. It always escalates.

- **Multiple Staff Converging**
  - Having 3–4 staff approach simultaneously feels threatening and overwhelms the patient. One calm staff member with a familiar face is almost always more effective.

What NOT to Do: Common Mistakes That Escalate

- **Rushing or Forcing**
  - Physically guiding or rushing a patient who is resisting amplifies the threat response. Slowing down — even if care takes longer — consistently produces better outcomes and fewer injuries.

- **Matching the Emotional Intensity**
  - Responding to agitation with a raised voice, tense posture, or reactive emotion mirrors the patient's state and escalates. Regulate yourself first — the patient will co-regulate with you.

Verbal Scripts That Work

- “You seem really upset right now — I want to help you feel better. Can you tell me what's bothering you?”
- “I hear you. That sounds really hard. I'm right here with you and I’m not going anywhere.”
- “Let’s take a little walk together — sometimes that helps. You lead, I’ll follow.”

Verbal Scripts That Work

Healthcare Consideration

These scripts are not magic words — they work because of the calm tone, the physical presence, and the genuine attunement behind them.

Practice delivering them slowly, gently, and without urgency.

Interactive Self-Assessment #1

Knowledge Check —

Select the beset response for the following scenario.

Interactive Self-Assessment #2

A resident with moderate dementia begins calling out, wringing her hands, and refuses to go to dinner. A CNA says, “Come on, Mrs. T. — it's dinnertime, let's go.” Mrs. T. pulls away and yells, “Leave me alone!”

A. Gently take Mrs. T.’s arm and guide her to the dining room, explaining that she needs to eat.

B. Pause. Sit next to Mrs. T. at eye level. Say: “You look like you're having a hard time. I'm here to help.” Offer a choice: “Would you like to sit here a few minutes, or maybe have a snack in your room?”

C. Document the refusal, notify the charge nurse, and move on to other residents.

Interactive Self-Assessment #2

A resident with moderate dementia begins calling out, wringing her hands, and refuses to go to dinner. A CNA says, “Come on, Mrs. T. — it's dinnertime, let's go.” Mrs. T. pulls away and yells, “Leave me alone!”

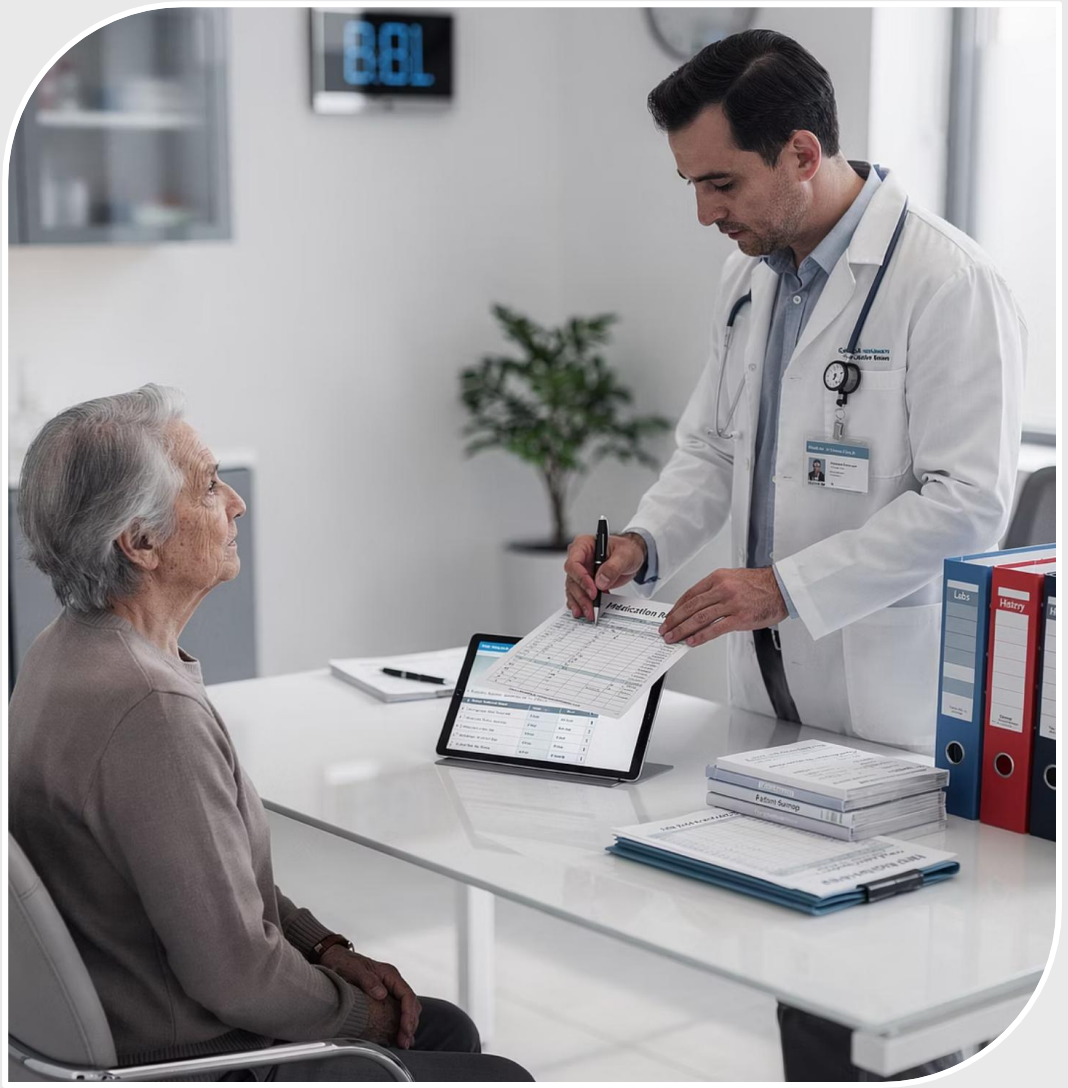
B. Pause. Sit next to Mrs. T. at eye level. Say: “You look like you're having a hard time. I'm here to help.” Offer a choice: “Would you like to sit here a few minutes, or maybe have a snack in your room?”

Option B is correct — it validates emotion, reduces pressure, offers control, and de-escalates without forcing compliance.

Pharmacologic Considerations

When Medications Enter the Picture

- Pharmacologic management of agitation in dementia carries **significant risks** and should be reserved for situations where non-pharmacologic interventions have been consistently implemented and failed, or where patient or staff safety is at immediate risk. The principle is always: **non-pharm first, lowest dose possible, shortest duration necessary.**



Appropriate Use and Significant Risks

- **When Medications May Be Appropriate**
  - Severe distress unresponsive to non-pharmacologic interventions
  - Risk of harm to patient or others that cannot be safely managed otherwise
  - Agitation driven by a treatable psychiatric condition (e.g., psychosis, major depression)
  - Short-term use during acute medical illness with behavioral decompensation

Black Box Warning: Antipsychotics

The FDA has issued a black box warning: **atypical antipsychotics increase mortality in elderly patients with dementia-related psychosis**. Risks include stroke, falls, over-sedation, and pneumonia.

- Use only with informed consent and documented rationale
- Start low, go slow — monitor closely
- Reassess monthly; taper and discontinue when possible
- Document that non-pharm was trialed first (regulatory requirement in LTC)

Medication Overview: What Is Used and Why

Medication Class	Examples	Clinical Notes
Atypical Antipsychotics	Quetiapine, Risperidone, Olanzapine	Off-label use; black box warning; avoid in Lewy body dementia; lowest effective dose
SSRIs/SNRIs	Sertraline, Citalopram, Escitalopram	First-line for anxiety and depression-driven agitation; better safety profile; takes weeks to work
Cholinesterase Inhibitors	Donepezil, Rivastigmine	Modest evidence for behavioral symptoms; primarily for cognitive symptoms
Benzodiazepines	Lorazepam, Diazepam	High-risk in elderly: falls, over-sedation, paradoxical agitation; use with extreme caution
Mood Stabilizers	Valproate, Carbamazepine	Mixed evidence; used when psychosis and mood instability co-occur; monitor for toxicity

Regulatory Note

In LTC, use of antipsychotics for behavioral symptoms without documented clinical indication is a F-tag citation. Documentation of non-pharmacologic attempts is essential.

When to Escalate

Knowing When to Escalate: A Decision Framework



Immediate Safety Risk

Patient or staff in danger; call for help and enact safety protocols.

Medical Emergency

Acute mental status or vital change; notify provider immediately.

Behavioral Failure to Respond

Non-pharmacologic measures exhausted; notify charge nurse and consult psychiatry.

Escalation is not a failure — it is a clinical skill. Knowing when your intervention is insufficient and acting promptly protects patients, staff, and your license. Document your assessment, what you tried, and the patient's response before and after escalation.

Clear Escalation Criteria

- **Immediate Physical Danger**
  - “That's not true — your husband passed away.” Correcting false beliefs causes acute grief and fear without any therapeutic benefit. It always escalates.

- **Severe Psychiatric Distress**
  - Having 3–4 staff approach simultaneously feels threatening and overwhelms the patient. One calm staff member with a familiar face is almost always more effective.

Clear Escalation Criteria

- **Suspected Medical Emergency**
  - Physically guiding or rushing a patient who is resisting amplifies the threat response. Slowing down — even if care takes longer — consistently produces better outcomes and fewer injuries.

- **Failure to Respond to Interventions**
  - Responding to agitation with a raised voice, tense posture, or reactive emotion mirrors the patient's state and escalates. Regulate yourself first — the patient will co-regulate with you.

Post-Episode: Debrief, Document, and Learn

- **Why Post-Episode Review Matters**
  - Every significant agitation episode is a learning opportunity. Post-incident review — done within 24 hours, with the involved staff — is the single most effective way to prevent recurrence and build team competency over time.
    - What triggered this episode?
    - Were early warning signs missed?
    - What interventions were tried and what worked?
    - What should be added to the care plan?

Post-Episode: Debrief, Document, and Learn

- **Documentation Requirements**
  - Thorough, objective behavioral documentation protects patients, staff, and facilities. Use behavioral descriptors, not interpretive language.
    - **Use:** “Patient struck CNA on arm three times when approached for bathing”
    - **Avoid:** “Patient was combative and uncooperative”
    - Document time, location, antecedents, behavior, response, and outcome
    - Update care plan with identified triggers and effective interventions

Evidence-Based Practice

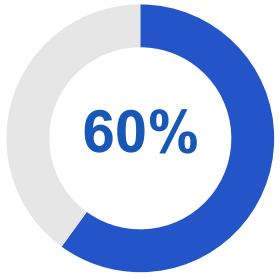
Person-Centered Care: The Foundation of Everything

Person-centered care is not a philosophy — it is a practice model with measurable outcomes. When care is organized around the individual's identity, history, preferences, and remaining strengths, **behavioral episodes decrease, quality of life improves, and staff satisfaction increases**.

Healthcare Consideration

CMS regulations under the Resident Rights provisions (F550–F584) mandate that care be delivered in a manner that honors individual dignity, autonomy, and preferences. Person-centered behavioral management directly aligns with these requirements.

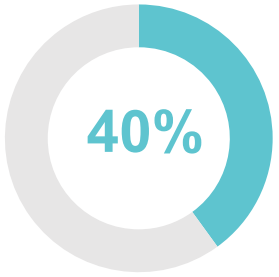
Key Evidence: What the Research Tells Us



Music Therapy

Reduction in agitation frequency with personalized music playlists during care tasks

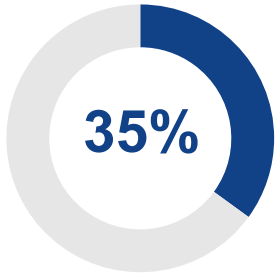
(Gerdner, 2000; Ridder et al., 2013)



Environmental Modification

Reduction in behavioral episodes with structured environmental intervention programs

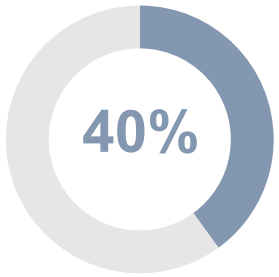
(Cohen-Mansfield, 2013)



Staff Education

Reduction in agitation-related incidents following structured dementia behavior training programs

(Livingston et al., 2014)



Antipsychotic Reduction

National average reduction in antipsychotic use achieved through CMS's National Partnership to Improve Dementia Care

Regulatory Considerations in Long-Term Care

- **F-Tag 758: Unnecessary Medications**
  - Medications must be used at the lowest effective dose, for the shortest duration necessary, with documented evidence that non-pharmacologic interventions were attempted. Antipsychotic use without adequate documentation is a citable deficiency.

- **CMS National Partnership Goal**
  - CMS's ongoing national initiative targets continued reduction of antipsychotic prescribing in nursing homes, with facilities required to report rates and demonstrate quality improvement efforts through QAPI programs.

Regulatory Considerations in Long-Term Care

- **Resident Rights and Dignity**
  - Every resident has the right to be free from unnecessary chemical and physical restraints. Behavioral documentation and structured non-pharmacologic care plans are not just best practice — they are federally mandated patient rights.

Self-Reflection

Self-Reflection: What Do *You* Bring to the Moment?

- Research consistently shows that **caregiver affect and behavior directly influence resident behavioral outcomes**. Our stress, urgency, fatigue, and frustration are perceived and responded to by patients — even those with severe dementia. Self-awareness is a clinical skill.

“The most important instrument in dementia care is the caregiver themselves.”



Questions for Professional Growth

- **“What early signs of agitation do I most often miss?”**
  - Be specific. Is it the subtle motor signs — pacing, fidgeting — before vocalization begins? Or the tone changes in voice? Identifying your personal blind spots allows you to close them.

- **“How does my own stress level affect my response?”**
  - On a difficult shift, when you're rushed or frustrated, what changes in your approach? Does your pace quicken? Does your tone tighten? How does the resident respond to that?

Questions for Professional Growth

- **“What is one thing I can change starting tomorrow?”**
  - Don't leave this session with a passive commitment to "do better." Choose one specific, observable behavior — an approach style, a communication habit, an assessment step — and implement it in your next shift.

- **“Am I caring for myself well enough to care for others?”**
  - Compassion fatigue and burnout are clinical risk factors — for both caregivers and patients. Regular self-care, supervision, and peer support aren't luxuries. They are professional necessities.

KEY TAKEAWAYS

What We Know — and What We Must Practice

- **Agitation = Communication**
  - Every behavioral episode is a message about an unmet need. Your job is to decode it — not suppress it. Ask “what is this person telling me?” before asking “what do I do about it?”

- **Non-Pharmacologic Strategies Are Most Effective**
  - Environment, routine, communication, and sensory approaches are evidence-based, lower-risk, and often more effective than medications. Use them first, consistently, and document them.

What We Know — and What We Must Practice

- **Early Recognition Prevents Escalation**
  - The window between early warning and full crisis is your most powerful intervention point. Build early-warning pattern recognition into every patient interaction, every shift.

- **Structured Response Improves Outcomes**
  - Teams that use consistent frameworks — PAUSE, assessment protocols, post-incident review — produce measurably better safety and quality-of-care outcomes than those relying on individual improvisation.

Your Action Checklist: Take This Back to Your Unit

- **For Individual Practice**
  - Use PAINAD or Abbey Pain Scale for nonverbal residents showing behavioral change
  - Apply the CAM tool when you see acute behavioral changes
  - Practice the PAUSE framework before every care interaction
  - Know one personalized comfort strategy for each of your regular patients
  - Document behaviors objectively, with antecedents, behaviors, and consequences

Your Action Checklist: Take This Back to Your Unit

- **For Your Team and Facility**
  - Advocate for consistent assignment policies
  - Request structured post-incident review after significant agitation episodes
  - Ensure behavioral care plans include specific non-pharmacologic interventions
  - Support antipsychotic reduction initiatives through documentation and communication
  - Share this knowledge with float staff and new hires on your unit

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Questions? Let's Continue the Conversation.

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CE Credit Information

- To receive continuing education credit for this session, please complete the post-test and evaluation form provided by your facility or CE provider.



Questions? Let's Continue the Conversation.

- **Thank you** for your commitment to improving care for individuals living with dementia. The work you do every day — the patience, the observation, the compassionate response — is what makes the difference between a crisis and a moment of genuine human connection.



You have completed the course:

Recognizing and Managing Agitation in Dementia

Thank you!