Agitation
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Agitation is intensified by the experience of stress during hospitalization.

- Physical stress: fatigue, acute illness, sleep deprivation &/or drug reaction/interaction.
- Psychosocial stress: environmental change, interruption of normal routines, sensory deficits or deprivation, social isolation, overwhelming or competing stimuli and demands that generally exceed the patient’s capacity to function or adapt.
- Additional stressors seen in demented states include loss of impulse control, impaired judgment, emotional lability, misinterpreting the environment, intrusiveness and meddling.

Agitation is often seen as a form of reactance behavior. When personal freedom is threatened or reduced the individual will attempt to regain freedom and perceived personal control in the environment. Health care providers frequently impose restrictions on behavior, which may be necessary as a function of the environment. Nurses are in the trenches upholding these restrictions and need to understand how restrictions affect behavior. The initial effort is in accurately identifying the behavior. Remember there are differences between endangering behavior and reactance behavior. Because of these differences, the interventions to minimize problem behavior will also be very different. Endangering behaviors are just plain irritating to everyone in the environment, but reactance behaviors may create risk for injury to the patient and to others in the environment.

Endangering Behaviors

- Aggressive actions (e.g., hitting, biting, kicking, pushing, spitting)
- Disruptive actions (e.g., loud singing, molesting other patients, intrusiveness, yelling, and unwillingness to be quiet during quiet times)
- Noisy disruptive behaviors: Noisy behavior may result in conflicts between patients, and staff, and generate team dysfunction; decreases helping behaviors; interferes with interpersonal and social judgments and reactions to social stress; and elevates blood pressures and decreases frustration tolerance

Reactance Behaviors

- Resistive behaviors (e.g., refusing nursing care or to cooperate, refusing to eat, and refusing to get up or go to bed)
- Reactance behaviors are typically manifested during times coinciding with self-care activities (e.g., toileting or bathing) in response to the constant invasions of privacy in meeting basic cares.
- Verbally aggressive behaviors (e.g., swearing, derogatory name calling, belittling efforts)

Basic Guidelines for Early Detection

- Know the patient: What specific risk factors are present?
- Think prevention: Identify what may prevent aggressive behavior.
- Use protective intervention last: Use restraint only when injury is imminent to the patient or others.

Strategies for Intervention

- Promote adequate hydration and nutrition: avoid caffeine to decrease physical stress
- Provide consistency in routine
- Offer choices when possible tailored to the patient’s needs and abilities.
- Provide consistent staffing when possible to reduce confusion and enhance orientation
- Reduce or eliminate noise
- Avoid relocation when possible.
- Promote orientation and compensate for any sensory deficits.
- Provide unsolicited contacts to reduce the possibility that the patient will decide that some attention is better than no attention.
- When resistance is encountered it feels personal. Avoid interpreting resistance as rejection.
- Provide regular or planned time outs or rest periods to compensate for fatigue and loss of reserve energy, the goal is to balance stimulation with quiet time.
- Intervene early to distract or move away from upsetting situations to prevent escalation
- Planned quiet times are used daily to decrease fatigue, resistance, and agitation through decreased demand for interaction and related tasks.