

Standard 4

Revised: 2003, 2006, 2009
Reviewed: 1991, 1994, 1997, 2000

CARE OF THE DISORIENTED PATIENT

OBJECTIVES:

1. To promote reality orientation.
2. To protect the patient from injury.
3. To promote participation in self-care within individual limitations.

PROCESS STANDARDS:

1. A therapeutic environment will be promoted i.e. eliminate unnecessary noise, well-lit room during waking hours and adequate light at night, adequate sleep time, calm/consistent communication and memory cues such as a clock/calendar.
2. Orientation will be done to time, place, person and situation (x 4) as needed but at least daily, and directions given in clear, simple terms. Family to provide their appropriate assistive devices (eye glasses, hearing aids which are clean and in working order).
3. The patient will be encouraged to participate in self-care.
4. The patient will be instructed not to get out of bed without assistance/supervision.
5. The patient will be supervised closely to prevent incurring harm to self or others.

OUTCOME STANDARDS:

At the time of discharge:

1. The patient will be optimally oriented x 4 within own limitations.
2. The patient will have incurred no injury.
3. The patient will demonstrate self care within own limitations.

HAVE I DOCUMENTED:

- * Orientation x 4
- * Safety Factors
 - Bed
 - Each visit with patient/family and interventions performed
- * Patient Education
 - Reason for safety measures

At The Time of Discharge:

- * Return to baseline in ability to perform self care and expresses satisfaction with activities completed for him/her
- * Orientation x 4
- * Patient/family has understanding of home and follow-up care

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Reference:

1. *Communication, Impaired verbal-related to physiologic or psychosocial changes*. Accessed 11/2/2009: [AR, LA, OK Libraries - LSU - Shreveport -- Nursing Diagnosis Reference Manual, Sparks and Taylor's - 7th Ed. \(2008\)](#). Lippincott Williams and Wilkins: Philadelphia.
2. Doenges et. al. *Nurses Pocket Guide: Diagnoses, Prioritized Interventions, and Rationales*. (2008). *Impaired Memory and Acute Confusion*: Accessed 8/19/2009 [Mosby's Nursing Consult - Reference Books](#).
3. Swearingen, P. *Manual of Medical Surgical Nursing Care*, 6th ed. Chapter 5: Neurologic disorders-self care deficit related to decreasing LOC to sensorimotor deficits. Accessed 10/29/2009 [Mosby's Nursing Consult - Reference Books](#).
4. Townsend, M. *Disturbed Sensory Perception*. Accessed 11/2/2009: [AR, LA, OK Libraries - LSU - Shreveport -- Nursing Diagnoses in Psychiatric Nursing - 7th Ed. \(2008\)](#). Pearson Prentiss Hall: Upper River Saddle: New Jersey.
5. Swearingen, P. *Manual of Medical Surgical Nursing Care*, 6th ed. Chapter 5: Neurologic disorders-self care deficit related to decreasing LOC to sensorimotor deficits. Accessed 10/29/2009 [Mosby's Nursing Consult - Reference Books](#).