Care of a Confused Patient

Introduction

Patients experiencing confusion require special nursing consideration. They may be aggressive, offensive, and belligerent. Confusion can be caused by multiple factors, including certain medical conditions, drug interactions, and substance abuse. When a patient is confused, his condition should be monitored for the cause of the confusion so that the source can be eliminated if possible.

Equipment

- Stethoscope
- Sphygmomanometer
- Thermometer
- Pulse oximeter

Implementation

- Review the patient's medical record for his previous functional level, medication history, laboratory test results, and medical and psychiatric diagnoses.

Nursing alert: Be aware that over-the-counter herbal medications and supplements as well as illegal drugs can cause confusion, especially when they interact with prescribed medications. Consider this factor when reviewing the patient's history.

1. Introduce yourself to the patient *to reduce his anxiety.*
2. Confirm the patient's identity using two patient identifiers according to your facility's policy.[3]
3. Explain to the patient any procedures or interventions, using simple terms and short sentences, before implementing them.
4. Assess the patient's orientation to time, place, person, and his environment.
5. Assess the patient for problems that he may be unable to describe, such as pain, a full bladder, shortness of breath, or the need to change position.
6. Obtain a baseline set of vital signs, including a pulse oxygen level. *Low blood pressure, low glucose levels, or oxygen saturation levels can cause confusion.*
7. Assess the environment for the risk of injury and eliminate any risks, if possible. Remove potentially harmful items, including sharp objects, combs, shoelaces, and items that can be used to cut or cause harm.
8. Remove extra stimuli that may add to confusion from the environment. For example, reduce the lighting, remove the patient from a crowded or overly noisy area, and talk with the patient in a calm reassuring manner.
9. Provide intermittent periods of soft music, *which tends to calm anxiety and trigger pleasant sensations*, or show family videos with familiar voices and faces, *which are usually a source of comfort for the patient.*

10. Reduce the patient's agitation by trying to identify and eliminate the cause rather than focusing on his behavior.
11. Obtain an order to discontinue any medications identified as causing interactions that can lead to confusion.
12. Make sure the patient is wearing glasses and hearing aids, as needed, and give him reasonable explanations for sights and sounds.
13. Provide clocks and calendars in the patient's room.
14. Provide reorientation to time, place, person, and the environment, as indicated, *to reduce patient anxiety.*

Nursing alert: Reorientation of the confused patient should be determined on an individual basis. Studies show that reorientation may actually increase agitation in patients.

1. Observe the patient continuously *to prevent wandering and injury.* If one-on-one monitoring isn't possible, position the patient close to staff for observation.
2. Encourage the patient's family to visit as frequently as possible. Family may also bring in familiar non-sharp objects such as pictures *to assist the patient with reorientation.*
3. Don't allow the patient to leave the unit unattended. A staff member familiar with the patient should accompany the patient to essential diagnostic tests and other appointments.
4. Document the procedure.[4]

Special Considerations

- All familiar objects provided by family members must be approved by staff before use.
- Medication assessment for potential interactions that may cause or increase confusion can be made by the pharmacist or doctor.
- Allow for proper breaks and meals away from the unit for staff members caring for a confused patient. *Staff members need breaks to prevent burnout.*

Patient Teaching

Teach the patient's family how to approach and communicate with a confused patient. Teach the patient and his family common causes of confusion, including drug interactions with herbal medications. Provide written drug education materials as needed.

Documentation

Document the admission nursing assessment and daily nursing assessment findings as well as observations at each shift (or more frequently as needed). Specific attention during documentation should be given to the patient's affect, energy level, level of orientation, eating pattern, and sleep pattern. Describe in detail any characteristics of confusion and any specific interventions that were successful in decreasing anxiety and confusion. Describe your progress in identifying the factors adding to the patient's confusion. Document the patient's

response to the environment and interaction with others. Document education provided to the patient or family.

References

1. Dahlke, S., and Phinney, A. "Caring for Hospitalized Older Adults at Risk for Delirium: The Silent, Unspoken Piece of Nursing Practice," *Journal of Gerontological Nursing* 34(6):41-47, June 2008.
2. Devlin, J.W., et al. "Assessment of Delirium in the Intensive Care Unit: Nursing Practices and Perceptions," *American Journal of Critical Care,* 17(6):555-565, November 2008.
3. The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: The Official Handbook.* Standard NPSG.01.01.01. Oakbrook Terrace, Il.: The Joint Commission, 2010.
4. The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: The Official Handbook.* Standard RC.01.03.01. Oakbrook Terrace, Il.: The Joint Commission, 2010.
5. Mohr, W.K. *Psychiatric-Mental Health Nursing: Evidence-Based Concepts, Skills, and Practices,* 7th ed. Philadelphia: Lippincott Williams & Wilkins, 2008.
6. Stenwall, E., et al. "Encountering the Older Confused Patient: Professional Carers' Experiences," *Scandinavian Journal of Caring Science* 21(4):515-22, December 2007.
7. Varcarolis, E.M., et al. *Foundations of Psychiatric Mental Health Nursing: A Clinical Approach,* 5th ed. St. Louis: Saunders, 2006.
8. Videbeck, S.L. *Psychiatric-Mental Health Nursing,* 4th ed. Philadelphia: Lippincott Williams & Wilkins, 2007.

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7. Obtain a baseline set of vital signs including a pulse oxygen level.
8. Assess the environment for the risk of injury and eliminate any risks, if possible.
9. Remove extra stimuli that may add to confusion from the environment.
10. Provide intermittent periods of soft music or show family videos with familiar voices and faces.
11. Reduce the patient's agitation by trying to identify and eliminate the cause.
12. Obtain an order to discontinue any medications as needed.
13. Make sure the patient is wearing glasses and hearing aids, as needed, and give him reasonable explanations for sights and sounds.
14. Provide clocks and calendars in the patient's room.
15. Provide reorientation to time, place, person, and his environment as indicated.
16. Observe the patient continuously.
17. Encourage the patient's family to visit as frequently as possible.
18. Don't allow the patient to leave the unit unattended.
19. Document the procedure.