

PROTOCOL FOR: Sensory Perception, Altered

DESIRED PATIENT
OUTCOMES:

1. Impaired verbal communication: the patient will communicate needs and desires effectively.
2. Visual impairment: the patient will learn methods of coping/compensating for loss of visual acuity.
3. Hearing Impairment: the patient will learn methods of communication to compensate for loss of hearing acuity.
3. Impaired swallowing: the patient will experience adequate swallowing as evidenced by absence of coughing and choking when eating and drinking.

CLINICAL
ASSESSMENT
AND CARE:

1. COMMUNICATION:
 - a. Definitions:
 - 1) Aphasia: deficit or loss of ability to comprehend or express spoken or written language.
 - 2) Dysphasia: lack of speech coordination and failure to arrange words in proper order.
 - 3) Dyslexia: reading difficulty.
 - 4) Dysgraphia: writing difficulty.
 - b. Assessment:
 - 1) Assess and document four communication modalities: reading, writing, listening and speaking.
 - 2) Assess for difficulties in verbal communication, i.e. slow scanning speech pattern, difficulty with articulation.
 - 3) Assess and document the patient's hearing function. If there is no impairment, speak in normal tone.
 - 4) Assess reliability of yes and no responses. If largely accurate (i.e. greater than 70% or so reliable), use yes and no question for communication, if appropriate.
 - c. General Nursing Care:
 - 1) Maintain a patient, calm approach; listen carefully, avoid interrupting the patient, allow ample time for communications.
 - 2) Simplify communication to patient's level of comprehension, e.g. one to two word phrases, one stage commands.
 - 3) Reduce environmental distractions providing consistent routine and environmental structure.

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- 4) Try to anticipate the patient's needs in order to minimize verbal communication. Use gestural cues to augment verbal communication.
- 5) Provide materials necessary for communication, i.e. magic slate board, pad and pencil, flash cards and picture board.
- 6) Encourage verbalization and offer positive feedback.
- 7) Consult speech pathologist regarding methods used with speech impairments. Reinforce exercises and techniques prescribed.
- 8) Instruct and include family and visitors regarding patient's level of comprehension and strategies for communication at that level.

2. VISION:

a. Assessment:

- 1) Assess for visual limitations (e.g. loss of visual fluid, pupil size, blurred vision).

b. General Nursing Care:

- 1) Always introduce yourself or announce your presence when entering the patient's room, and let the patient know when you are leaving.
- 2) Modify environment to maximize any vision the patient may have (i.e. place objects within visual field, approach patient from the best visual angle).
- 3) Teach and cue patient to look to side of visual impairment and to check on placement of affected limbs.
- 4) Provide sensory stimulation by using tactile, auditory and gustatory stimuli to help compensate for visual loss (i.e. large print books, audiotapes, radio).
- 5) Give patient clear, concise explanation of treatment and procedures.
- 6) Ensure health care personnel are aware of vision loss. (May place sign over patient's bed).
- 7) Assist patient with alternative ways of coping with vision loss; use of adaptive devices (i.e. eyeglasses, magnifying glass).

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3. SWALLOWING:

a. Definitions:

- 1) Dysphagia: difficulty swallowing.

b. Assessment:

- 1) Assess for signs and symptoms of impaired swallowing and risk for aspiration.
- 2) Assess gag reflex PRN.

c. General Nursing Care:

- 1) Consult Speech and Occupational Therapy regarding methods of dealing with impaired swallowing. Reinforce exercises and techniques prescribed.
- 2) Assist with or observe the patient's eating as needed. Place small bites of food in unaffected side of mouth. Semi-solid foods may be handled better than liquids. Provide cues for: wiping, checking pockets in mouth, discussing rate of swallowing, and completing the swallow before the next bite.

- SAFETY MEASURES:
1. Maintain suction set-up at bedside.
 2. Assess presence of cough reflex and ability to swallow before giving patient anything by mouth.
 3. Provide appropriate call bell (e.g. Touch Pad).
 4. Educate family re: patient's ability/inability to eat/drink.

APPROVAL: Medical-Surgical Standards Review
Nursing Standards Committee

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