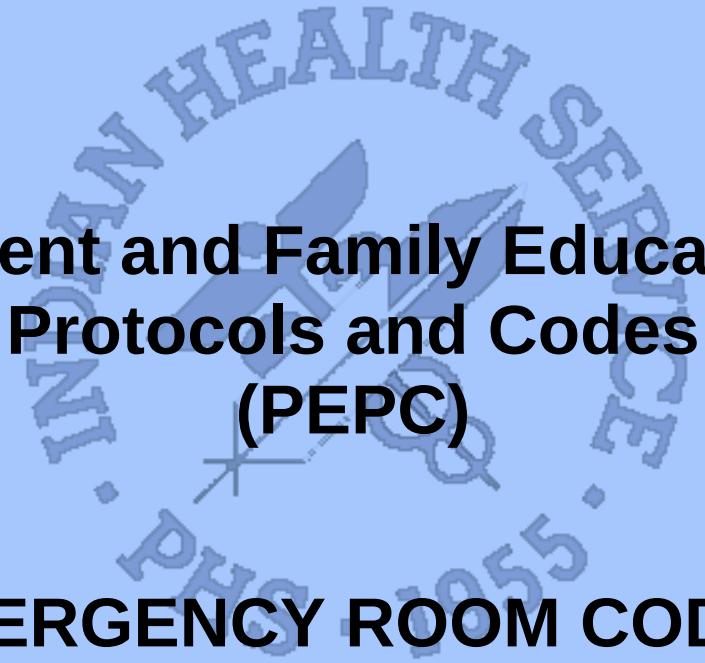
INDIAN HEALTH SERVICE



Patient and Family Education Protocols and Codes (PEPC)

EMERGENCY ROOM CODES

11th Edition
January 2005

FOREWORD

The PEP-C (Patient Education Protocols and Codes committee) has diligently worked to add all protocols that were requested by providers or departments. We hope that you find codes helpful in documenting your patient education. Some of the codes found in this book will be used in ORYX and GPRA as indicators. Please consult your local SUD to see which indicators your site has chosen. More information about these topics can be obtained from Mary Wachacha or Mike Gomez. They are both in the IHS e-mail system.

As co-chairs of this committee we would like to sincerely thank all the members and guests of this committee. As usual they spent long hours preparing for the committee meeting and even longer hours in committee. They all deserve our appreciation. Without these dedicated committee members this would not be possible. We would also like to thank Mary Wachacha, IHS Chief of Health Education. Without her vision none of this would be possible. We would like to recognize Liz Dickey, R.N. for her part in envisioning an easier way to document education. We would like to thank Juan Torrez for his assistance in formatting and ensuring consistency in our document. We would like to thank all the programs in IHS for their dedication to the documentation of patient and family education. Finally, we are indebted to our colleagues in the Indian Health Service for their support, encouragement and input.

If you have new topics or codes you would like to see in future editions of the Patient Education Protocols and Codes please let us know. Submissions are requested and encouraged!!! Please e-mail submissions or mail them on floppy disk, in Word or Word Perfect format. Please try to follow the existing format as much as possible and as much as possible use mnemonics (codes) that are already in existence. The submissions will be reviewed by the committee and may be changed extensively prior to their publication for general use. New submissions should be sent to:

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FOREWORD TO THE 11TH EDITION OF THE PATIENT EDUCATION PROTOCOLS

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Use and Documentation of Patient Education Codes

Why Use the Codes?

Use of the codes helps nurses, physicians and other health care providers to document and track patient education. While it is frequently desirable to spend 15, 30 even 60 minutes making an assessment of need, providing education and then documenting the encounter, the reality of a busy clinical practice often requires us to do this in a more abbreviated fashion. The codes allow the educator a quick method of documenting that education took place during a given patient visit. The codes are then transferred to the health summary which informs everyone using the chart that a given patient received education on specific topics. The codes are limited in that they do not detail the exact nature of the education. However, using these codes consistently will show the pattern of education provided and encourage subsequent health professionals to do the appropriate follow-up. For instance, a typical health summary for a diabetic patient might show the following history of patient education:

07/19/04 DM-Nutrition, poor understanding, 10 min. (Provider Initials) GS: Pt. will include 5 veg/fruit/day

10/27/04 DM-Foot care, good understanding, 7 min. (Provider Initials)GM: Pt included 5 veg/fruit/day

11/07/04 DM-Exercise, good understanding, 15 min. (Provider Initials) GS: Pt. will walk 5 dys/wk/30 min.

A reasonable interpretation of this summary tells you that this patient is trying to understand management of their diabetes.

SOAP Charting and the Codes

Use of the codes *does not* preclude writing a SOAP note on educational encounters. Whenever a health professional spends considerable time providing education in a one-on-one setting, that visit should be recorded as an independent, stand-alone visit. The primary provider can incorporate the educational information into their SOAP note and use the code to summarize the visit and get the information onto the health summary. If the patient sees both a physician and a nurse during the same visit and the nurse completes a lengthy educational encounter, two PCC forms should be used— one for the physician visit and one for the nursing visit. In that particular case the patient had two primary care encounters during the same day.

How to Use the Codes

The Medical Records and Data Entry programs at each site determine where patient education will be entered on the PCC and other facility forms. Medical Records and Data Entry will also determine how the patient education is recorded. You should check with your Medical Records and Data Entry staff to determine how they would like your facility to document patient education. Using a stamp, over-printing on the PCC or the use of "education flow sheets" is discouraged for all disciplines and all sites. All education should be documented directly onto the PCC, PCC+ and in the Electronic Health Record.

The educator should document the education using the following steps:

1. Log onto the PCC, PCC+ or Electronic Health Record or document the education on the PCC Group Preventive Services Form
2. Circle "Patient Education" in the section marked "Medications/Treatment/Procedures/Patient Education"
3. If using the PCC+ or the Electronic Health Record, Patient Education is located in specific sections of the PCC+ and Electronic Health Record.
4. Begin your documentation by entering the appropriate:
    - STEP ONE: Write down the appropriate ICD-9 code, disease, illness or condition for which you are providing the education.
    - STEP TWO: Enter the education topic discussed (e.g. complications, nutrition, hygiene).
    - STEP THREE: Determine the patient's level of understand of the education provided and enter as good- (G), fair (F), or Poor (P).
        - If the patient refuses the education encounter, you document this refusal by writing an (R) for refused.
        - If you are providing education in a group (not an individual one-on-one encounter), the education provided is documented as (GP) for Group education. A "group" is defined as more than one person. Documenting with the Group (Gp) mnemonic indicates that the group member's level of understanding was not assessed.
    - STEP FOUR: Enter the amount of time spent educating the patient. Use specific time amounts rounded off to the minute, i.e., 3 minutes, 17 minutes.
    - STEP FIVE: Initial your entry so that you can get credit for the education provided.
    - STEP SIX: Lastly, each provider is able to encourage the patient to participate in the determination of their personal health by setting a goal for themselves. This capability is the last item documented at the end of

the educational encounter. The provider assists the patient in setting a "plan of action" for themselves to aid in the improvement of their health. This is documented by using (GS) for Goal Set; (GM) for Goal Met; and (GNM) for Goal Not Met. Upon the documentation of the setting of a Goal, each subsequent health care provider can refer to the "Health Summary" and look under the "Most Recent Patient Education" to review any goals set by the patient.

OBJECTIVE	DEFINITION	MNEMONIC
Goal Set	• State a plan; • State a plan how to maintain at least one _____; • Write a plan of management; • Plan to change ___; • A plan to test _____(blood sugar); • Choose at least one change to follow _____; • Demonstrate ____ and state a personal plan for _____; • Identify a way to cope with _____;	GS
Goal Met	Behavior Goal Met	GM
Goal Not Met	Behavior Goal Not Met	GNM

The PCC Coders can only select "Good, Fair, Poor, Group or Refused" for the level of understanding. Remember, this section is meant for speedy documentation of brief educational encounters. If you wish to write a more lengthy narrative, please do so, on a separate PCC form using the codes to simply summarize your note. On inpatient PCCs each entry must be prefaced by a date.

Recording the Patient's Response to Education

The following "Levels of Understanding" can be used in the PCC system:

Good (**G**):	Verbalizes understanding Verbalizes decision or desire to change (plan of action indicated) Able to return demonstrate correctly
Fair (**F**):	Verbalizes need for more education Undecided about making a decision or a change Return demonstration indicates need for further teaching
Poor (**P**)	Does not verbalize understanding Refuses to make a decision or needed changes Unable to return demonstrate
Refuse (**R**):	Refuses education
Group (**Gp**):	Education provided in group. Unable to evaluate individual response

Documenting Patient Education (Forms)

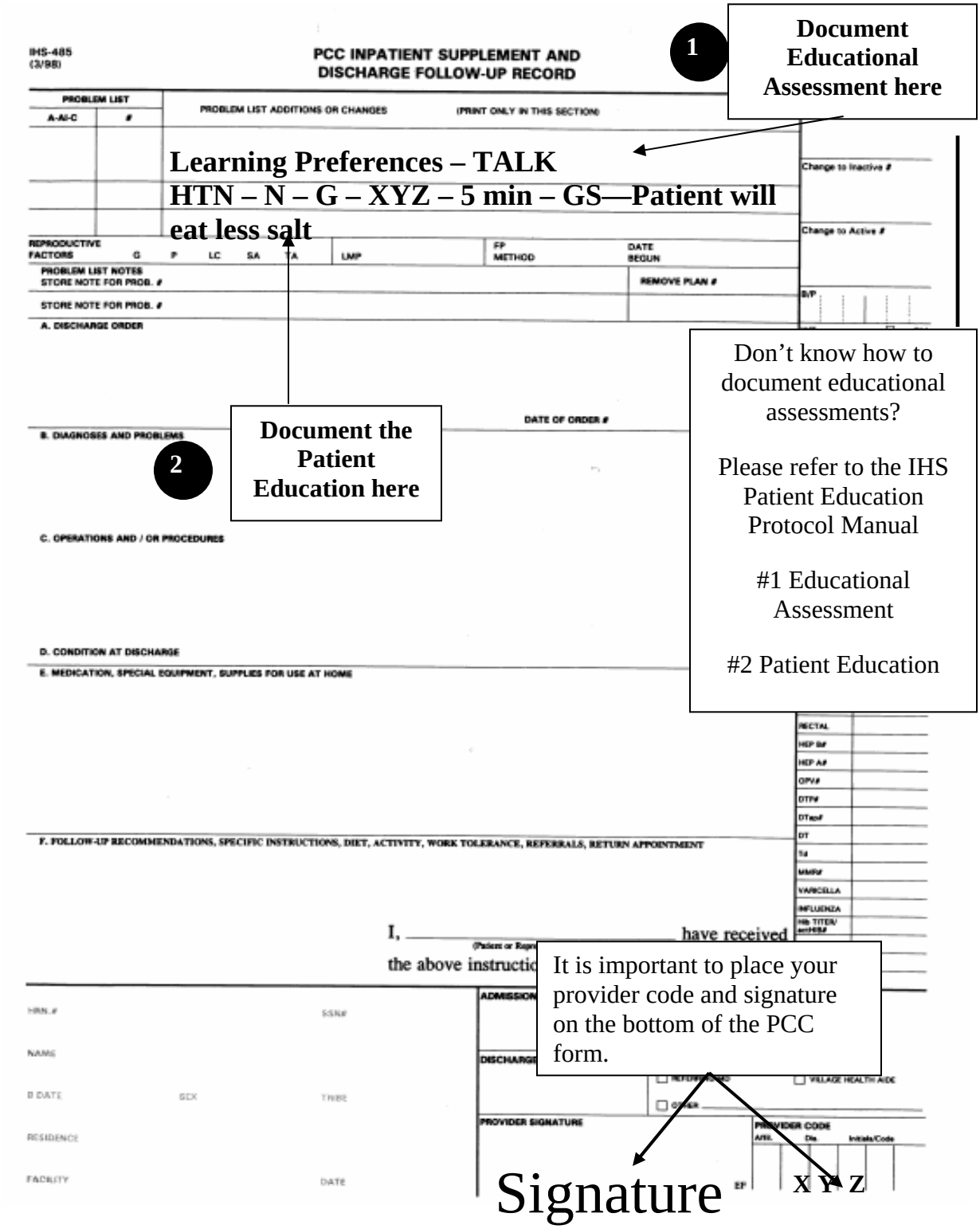


Figure 1: ***Documenting Patient Education on the PCC Inpatient Supplement and Discharge Follow-Up Record form.***

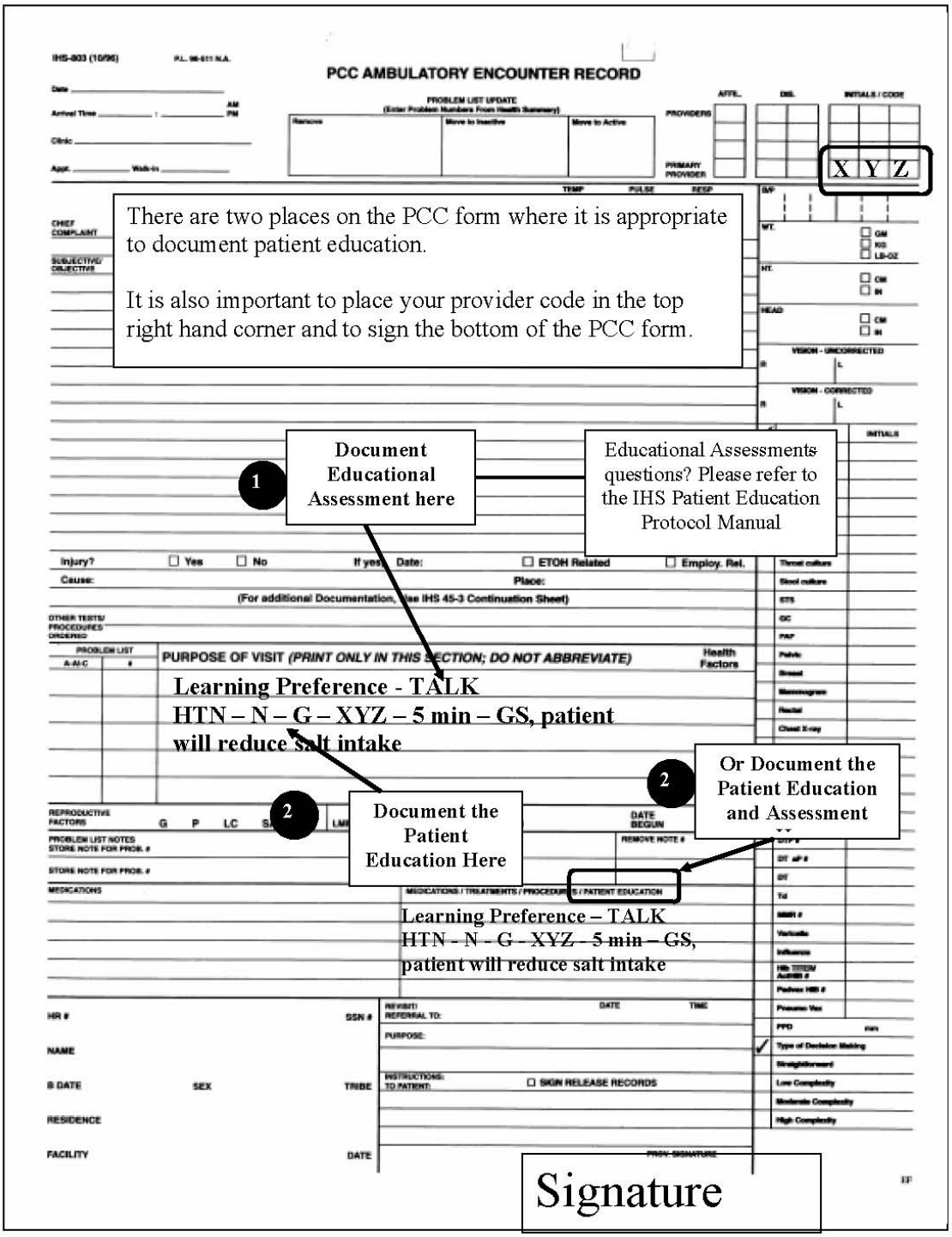


Figure 2: Documenting Patient Education with the PCC Ambulatory Encounter Record form

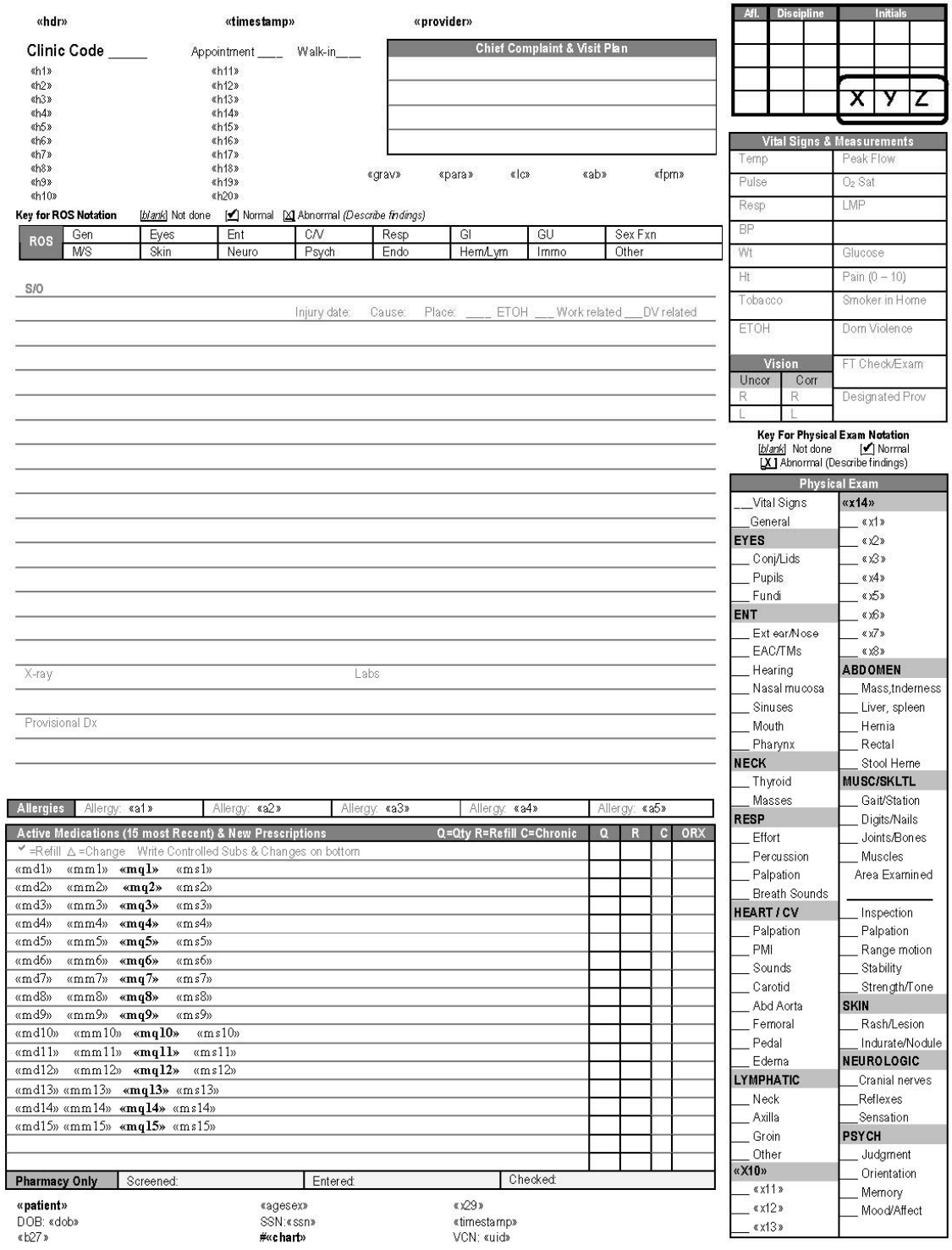


Figure 3: Documenting Patient Education on a PCC+ form, page 1

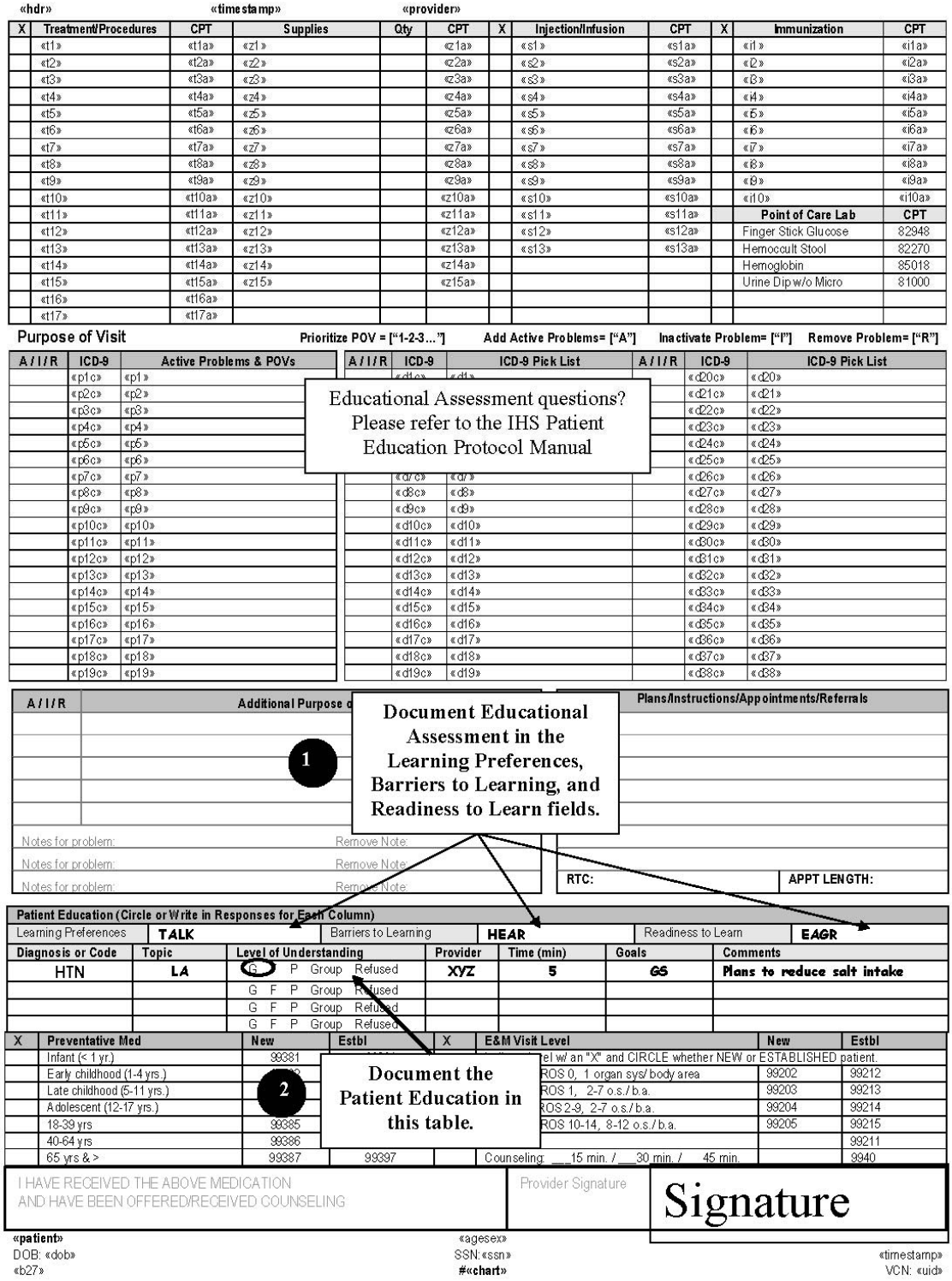
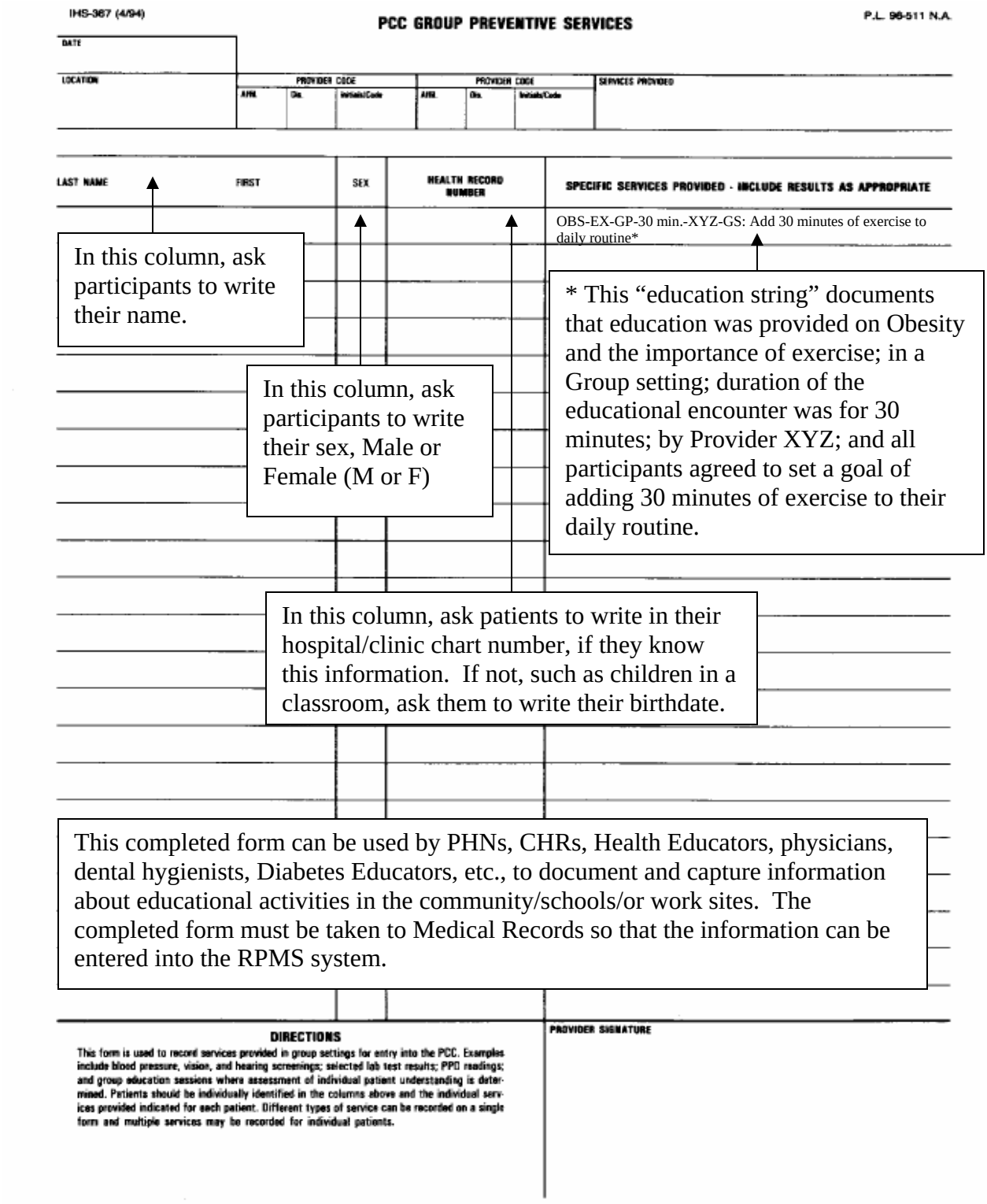


Figure 4: Documenting Patient Education on a PCC+ form, page 2

USE AND DOCUMENTATION OF PATIENT EDUCATION CODES

This form is used by all healthcare workers providing education in the community, schools, work sites, etc.



IHS-367 (4/94)

PCC GROUP PREVENTIVE SERVICES

P.L. 98-511 N.A.

DATE

LOCATION

PROVIDER CODE (AFIL. | Dis. | Initials/Code)

PROVIDER CODE (AFIL. | Dis. | Initials/Code)

SERVICES PROVIDED

LAST NAME	FIRST	SEX	HEALTH RECORD NUMBER	SPECIFIC SERVICES PROVIDED - INCLUDE RESULTS AS APPROPRIATE
				OBS-EX-GP-30 min.-XYZ-GS: Add 30 minutes of exercise to daily routine*

In this column, ask participants to write their name.

In this column, ask participants to write their sex, Male or Female (M or F)

* This "education string" documents that education was provided on Obesity and the importance of exercise; in a Group setting; duration of the educational encounter was for 30 minutes; by Provider XYZ; and all participants agreed to set a goal of adding 30 minutes of exercise to their daily routine.

In this column, ask patients to write in their hospital/clinic chart number, if they know this information. If not, such as children in a classroom, ask them to write their birthdate.

This completed form can be used by PHNs, CHRs, Health Educators, physicians, dental hygienists, Diabetes Educators, etc., to document and capture information about educational activities in the community/schools/or work sites. The completed form must be taken to Medical Records so that the information can be entered into the RPMS system.

DIRECTIONS

This form is used to record services provided in group settings for entry into the PCC. Examples include blood pressure, vision, and hearing screenings; selected lab test results; PPD readings; and group education sessions where assessment of individual patient understanding is determined. Patients should be individually identified in the columns above and the individual services provided indicated for each patient. Different types of service can be recorded on a single form and multiple services may be recorded for individual patients.

PROVIDER SIGNATURE

USE AND DOCUMENTATION OF PATIENT EDUCATION CODES

READINESS TO LEARN
(RL Code)

Eager to Learn	**RL-EAGR**
Receptive	**RL-RCPT**
Unreceptive	**RL-UNRC**
Pain	**RL-PAIN**
Severity of Illness	**RL-SVIL**
Not Ready	**RL-NOTR**
Distraction	**RL-DSTR**

Assessed each teaching session

PATIENT'S RESPONSE TO EDUCATION (Level of UNDERSTANDING)

GOOD (G) - Verbalized understanding. Verbalizes decision to change (plan of action indicated) able to demonstrate correctly.
FAIR (F) - Verbalizes need for more education. Undecided about making a decision or change. Return demonstration indicates need for further teaching.
POOR (P) - Does not verbalize understanding. Refuses to make a decision or needed changes. Unable to return demonstration.
REFUSED (R) - Refuses education.
GROUP (GP) – Group taught

LEARNING PREFERENCES (LP Code)
Assessed Yearly
If Assessed Today, Today's Date:

Talk (one-on-one)	**LP-TALK**
Video	**LP-VIDO**
Group	**LP-GP**
Read	**LP-READ**
Do/Practice	**LP-DOIT**

BARRIERS TO LEARNING - BAR (Assessed Annually); If Assessed Today, Date Assessed:
Check those that apply:

☐ No Barriers **BAR-NONE**
☐ Doesn't read English **BAR-DNRE**
☐ Interpreter Needed **BAR - INTN**
☐ Social Stressors **BAR-STRS**
☐ Cognitive Impairment **BAR-COGI**
☐ Blind **BAR-BLND**
☐ Fine Motor Skills **BAR-FIMS**
☐ Hard of Hearing **BAR-HEAR**
☐ Deaf **BAR-DEAF**
☐ Visually Impaired **BAR-VISI**
☐ Values/Beliefs **BAR-VALU**
☐ Emotional Impairment **BAR- EMOI**

List measures taken to address above barriers:

Comments: ____

DATE	PATIENT EDUCATION	(Check box to refer to Progress Notes)	PROVIDER INITIALS OR PROVIDER CODE	READINESS TO LEARN CODE (RL)	LEVEL OF UNDER-STANDING CODE	PERSON TAUGHT	TIME	GOAL SET GOAL MET GOAL NOT MET	CPT CODE
	ICD-9 CODE DISEASE STATE, ILLNESS OR CONDITION	EDUCATION TOPIC							
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
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		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			

Patient Identification

Providers please sign on back of form

Signature:	Initials/Provider code:	

Reimbursement for Patient Education

Preventive Medicine Services

Evaluation and Management (E&M) CPT Coding and ICD-9 Diagnostic Coding

Reimbursement for Patient Education

To properly document and receive reimbursement for patient education services, it is important to provide enough document to substantiate accurate CPT Procedural Coding and ICD-9 Diagnostic Coding. These two types of codes are mandatory to properly complete the claim forms that will be submitted to third party payers.

For CPT Coding, the reimbursement of patient education would fall under the Evaluation and Management (E&M) Codes based on *Time*. *Time* is a factor in clinical encounters. The most common and most important element that *'Time'* becomes a factor is when counseling dominates the visit (i.e. patient education).

"In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (fact-to-face time in the office or other outpatient setting, floor/unit time in the hospital or nursing facility), *Time* is considered the key or controlling factor to qualify for a particular level of E/M services.

The following codes are used to report the preventive medicine evaluation and management of infants, children, adolescents and adults. The extent and focus of the services will largely depend on the age of the patient.

If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier '-25' should be added to the Office/Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported. The "comprehensive" examination of the Preventive Medicine Services codes 99381-99397 is NOT synonymous with the "comprehensive" examination required in Evaluation and Management codes 99201-99350.

Codes 99381-99397 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination. (Refer to codes 99401-99412 for reporting those counseling/anticipatory

guidance/risk factor reduction interventions that are provided at an encounter separate from the preventive medicine examination.)

If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of *Time* of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care."

In practice, this means that if you document spending >50% of a 15 minute visit in counseling (education), you get a 99213 code even if you don't ask a single question or touch the patient. Similarly, >50% of a 25 minute encounter gets you 99214. IHS providers do provide patient education and counseling but most sites are neglecting to charge for these services. We either do not document the actual time spent or the content of the counseling. Certainly the private sector charges for these services.

Definition: Discussion with patient when 50% or more of the total physician face to face time of the encounter includes:

- Results of diagnostic tests or impressions
- Prognosis
- Risk and benefits of treatment options
- Instructions for care at home and follow-up with physician/other provider of care
- Importance for compliance with treatment plan
- Risk factor education, e.g., diet, exercise
- Patient and Family Education regarding disease and or the disease process

Documentation Requirements:

- Total face to face time is the basis for code selection
- 50% or more of the encounter is counseling
- Documentation of the total time of the encounter and the counseling Time
- Document a summary of the counseling performed
- Document any history or exam that was performed

Coordination of Care

Definition: When 50% of more of the total time of the encounter includes:

- Establishing and/or reviewing patient's record
- Documenting in the patient's medical record
- Communication with nursing staff, other physicians or health professionals and/or patient's family
- Scheduling treatment, ordering testing and/or x-rays

Important Aspects concerning Reimbursement for PATIENT EDUCATION

- Third Party claims should be processed for Medicare Part B eligible patients. Medicare Part A does not reimburse for these services
- Each site should contact their local payers and research the billing rules and regulations of ALL third party payers to determine if they will reimburse for patient education services.
- You must identify (the education provided) and routinely document the services and have PCC Data Entry enter the information by using the appropriate CPT code
- Identify who provided the service i.e., physician, PHN, FNP, PA, RD
- Education may be covered by an alternate resource as part of their plan coverage
- Use those CPT codes that are related to education
- "Incident To" services are billable

Documentation of Evaluation and Management (E/M) Services

- Three Key Components:
  - history
  - examination
  - medical decision making
- Other Components:
  - Counseling
  - Time (may use to determine Office Visit level if > 50% of time is spent in face-to-face counseling)

BRIEF Sample - Office Visits, Established Patients

CODES	99211	99212	99213	99214	99215
History	Not Required	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
Exam	Not Required	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
Decision Making	Not Required	Straight Forward	Low	Moderate	High
Time	5 Minutes	10 Minutes	15 Minutes	25 Minutes	40 Minutes

New Patient: Initial preventive medicine evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk facto reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures

Established Patient: Periodic preventive medicine reevaluation and management of an individual including a comprehensive history, comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory /diagnostic procedures

PROCEDURAL TERMINOLOGY	
CPT Codes	**Description of Procedure**
G0108	Diabetes Education – Group Education
G0109	Diabetes Education – Individual Education
97802	Medical Nutrition Therapy (MNT)
97803	Hospital-Observation/In-Patient
97804	Hospital-Observation/In-Patient
99201	Office Visit, New Patients-Office or other outpatient
99202	Office Visit, New Patients-Office or other outpatient
99203	Office Visit, New Patients-Office or other outpatient
99204	Office Visit, New Patients-Office or other outpatient
99205	Office Visit, New Patients-Office or other outpatient
99211	Office Visits, Established Patients-Office of other outpatient
99212	Office Visits, Established Patients-Office of other outpatient
99213	Office Visits, Established Patients-Office of other outpatient
99214	Office Visits, Established Patients-Office of other outpatient
99215	Office Visits, Established Patients-Office of other outpatient
99218	Hospital-Observation/In-Patient
99219	Hospital-Observation/In-Patient
99220	Hospital-Observation/In-Patient
99381	Preventive Medicine – New Patient Infant Age under 1 year
99382	Preventive Medicine – New Patient Early childhood (age 1 through 4 years)

PROCEDURAL TERMINOLOGY	
CPT Codes	**Description of Procedure**
99384	Preventive Medicine – New Patient Adolescent (age 12 through 17 years)
99385	Preventive Medicine – New Patient 18 – 39 years
99386	Preventive Medicine – New Patient 40 – 64 years
99387	Preventive Medicine – New Patient 65 years and over
99391	Preventive Medicine – Established Patient early childhood (age 1 to 4 years)
99392	Preventive Medicine – Established Patient - late childhood (age 5 to 11 years)
99393	Preventive Medicine – Established Patient - adolescent (age 12 to 17 years)
99394	Preventive Medicine – Established Patient - 18 – 39 years
99395	Preventive Medicine – Established - 40 – 64 years
99396	Preventive Medicine – Established - 65 years and over
99397	Preventive Medicine – Established - 65 years and over
99401	Preventive Medicine Evaluation and Management counseling and/or risk factor reduction intervention(s) provided to a New or Established Patient
99402	Preventive Medicine-Evaluation and Management New and Established approximately 30 min.
99403	Preventive Medicine-Evaluation and Management New and Established approximately 45 min
99404	Preventive Medicine-Evaluation and Management New and Established approximately 60 min.
99411	Preventive Medicine Counseling/Education and/or risk factor reduction intervention(s) provided to individuals in a ***group*** setting (separate procedure); – Established Patients approximately 30 minutes.
99412	Preventive Medicine Counseling/Education and/or risk factor reduction intervention(s) provided to individuals in a *group* setting (separate procedure); – Established Patients approximately 60 minutes.

The ICD-9 Diagnostic codes will be used for coding diagnoses that support the provision of these educational services. Below are major codes identified that can be used for guidance.

ICD-9 DIAGNOSTIC CATEGORIES	
ICD9 Code Range	**Name of Category**
V65.3	Dietary surveillance and counseling
V65.40	Counseling NOS
V65.41	Exercise Counseling
V65.42	Counseling on Substance use/abuse
V65.43	Counseling on Injury Prevention
V65.44	HIV counseling
V65.45	Counseling on other STDs
V65.49	Other specified counseling
V65.5	Person with feared complaint in whom no diagnosis was made
V65.8	Other reasons for seeking consultation
V65.9	Unspecified reason for consultation

General Education Codes

Guidelines For Use

These general education codes were developed in response to the ever-expanding list of patient education codes. The following 18 codes are education topic modifiers which can be used in conjunction with any ICD-9 diagnosis to document patient and family education. The following list is NOT exhaustive, nor is it intended to be.

This newer, more general system is used in essentially the same way as the specific codes, except that instead of having a patient education diagnosis code the provider will simply write out the 1) diagnosis or condition, 2) followed by the education modifier, 3) level of understanding, 4) write your Provider Initials, 5) Time spend providing the education, and 6) finally write down if the patient set a goal for them selves using GS for Goal Set, GM for Goal Met, and GNM for Goal Not Met. For example:

Head lice - TX - P - <provider initials>10 min. – GS: Pt. will wash bed linens

This would show up on the health summary under the patient education section as:

Head lice - treatment - poor understanding, 10 minutes ,, <Provider Initials> Goal Set: Patient will wash bed lines.

If education on more than one topic on the same diagnosis is provided these topics should be written on a separate line in the Patient Education section of the PCC, PCC+ and Electronic Health Record.:

For example:

Head lice - P - P - <provider initials>10 min. – GS: Pt. will wash bed linens
Head lice - TX - G - <provider initials>7 min. – GS: Pt. will wash bed linens
Impetigo - M, FU - G - <provider initials>GS: Pt. will practice good hygiene by not sharing items.

This would show up on the health summary under the patient education section as:

Head lice - prevention - poor understanding10 min. – GS: Pt. will wash bed linens
Head lice - treatment - good understanding 7 min. – GS: Pt. will wash bed linens
Impetigo - medications, follow-up - good understanding: Pt. will practice good hygiene by not sharing items.

Please note that for reimbursement, the Education MUST have an associated ICD-9 diagnosis code. These codes must still be documented in the patient education section of the PCC, PCC+ or on the EHR. The levels of understanding have not changed and are **G=good, F=fair, P=poor, R=refused, and Gp=group.**

The committee would like to thank Lisa Hakanson, R.D. for her suggestion that resulted in this addition.

General Education Topics

AP - ANATOMY AND PHYSIOLOGY

OUTCOME: The patient and/or family will have a basic understanding of anatomy and physiology as it relates to the disease state or condition.

STANDARDS:

1. Explain normal anatomy and physiology of the system(s) involved.
2. Discuss the changes to anatomy and physiology as a result of this disease process or condition, as appropriate.
3. Discuss the impact of these changes on the patient's health or well-being.

C - COMPLICATIONS

OUTCOME: The patient and/or family will understand the effects and consequences possible as a result of this disease state/condition, failure to manage this disease state/condition, or as a result of treatment.

STANDARDS:

1. Discuss the common or significant complications associated with the disease state/condition.
2. Discuss common or significant complications which may be prevented by full participation with the treatment regiment.
3. Discuss common or significant complications which may result from treatment(s).

DP - DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology, symptoms and prognosis of his/her illness or condition.

STANDARDS:

1. Discuss the current information regarding causative factors and pathophysiology of this disease state/condition.
2. Discuss the signs/symptoms and usual progression of this disease state/condition.
3. Discuss the signs/symptoms of exacerbation/worsening of this disease state/condition.

EQ - EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate (when appropriate) proper use and care of home medical equipment.

STANDARDS:

1. Discuss indications for and benefits of prescribed home medical equipment.
2. Discuss types and features of home medical equipment as appropriate.
3. Discuss and/or demonstrate proper use and care of home medical equipment, participate in return demonstration by patient/family.
4. Discuss signs of equipment malfunction and proper action in case of malfunction.
5. Emphasize safe use of equipment, i.e., no smoking around O_2, use of gloves, electrical cord safety, and disposal of sharps.
6. Discuss proper disposal of associated medical supplies.

EX - EXERCISE

OUTCOME: The patient/family will understand the relationship of physical activity to this disease state, condition or to health promotion and disease prevention and develop a plan to achieve an appropriate activity level.

STANDARDS:

1. Explain the normal benefits of a regular exercise program to health and well-being.
2. Review the basic exercise or activity recommendations for the treatment plan.
3. Discuss the relationship of increased physical activity or limited physical activity as applicable to this disease state/condition.
4. Assist the patient/family in developing an appropriate physical activity plan.
5. Refer to community resources as appropriate.

FU - FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

HM - HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of their disease process and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer emergency room visits, fewer hospitalizations, and fewer complications.
3. Explain the use and care of any necessary home medical equipment.

HY - HYGIENE

OUTCOME: The patient will recognize good personal hygiene as an aspect of wellness.

STANDARDS:

1. Discuss hygiene as part of a positive self image.
2. Review bathing and daily dental hygiene habits.
3. Discuss the importance of hand-washing in infection control.
4. Discuss the importance of covering the mouth when coughing or sneezing.
5. Discuss any hygiene habits that are specifically pertinent to this disease state or condition.

L - PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the disease process or condition.

STANDARDS:

1. Provide patient/family with written patient information on the disease state or condition.
2. Discuss the content of patient information literature with the patient/family.

LA - LIFESTYLE ADAPTATIONS

OUTCOME: The patient will strive to make the lifestyle adaptations necessary to prevent complications of the disease state or condition or to improve mental or physical health.

STANDARDS:

1. Review lifestyle aspects/changes that the patient has control over - diet, exercise, safety and injury prevention, avoidance of high risk behaviors, and full participation with treatment plan.
2. Emphasize that an important component in the prevention or treatment of disease is the patient's adaptation to a healthier, lower risk lifestyle.
3. Review the community resources available to assist the patient in making lifestyle changes. Refer as appropriate.

M - MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
2. Emphasize the importance of full participation with medication regimen.
3. Discuss the mechanism of action as needed.
4. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
5. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

N - NUTRITION

OUTCOME: The patient will understand the need for balanced nutrition and plan for the implementation of dietary modification if needed.

STANDARDS:

1. Review normal nutritional needs for optimal health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss nutritional modifications as related to the specific disease state/condition.
4. Emphasize the importance of full participation to the prescribed nutritional plan.

P - PREVENTION

OUTCOME: The patient/family will understand that healthy lifestyle behaviors can reduce the risk of developing diseases, conditions, or complications.

STANDARDS:

1. List lifestyle habits that increase the risk for the onset, progression, or spread of a specific disease/condition.
2. Identify behaviors that reduce the risk for the onset, progression, or spread of a specific disease/condition, i.e., immunizations, hand washing, exercise, proper nutrition, use of condoms.
3. Assist the patient in developing a plan for prevention.

PRO - PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure, including indications, complications, and alternatives, as well as possible results of non-treatment.

STANDARDS:

1. Discuss the indications, risks, and benefits for the proposed procedure.
2. Explain the process and what to expect after the procedure.
3. Explain the necessary preparation, i.e., bowel preps, diet instructions, bathing.
4. Discuss pain management as appropriate.
5. Emphasize post-procedure management and follow-up.

S - SAFETY

OUTCOME: The patient/family will understand principles of injury prevention and plan a safe environment.

STANDARDS:

1. Explain that injuries are a major cause of death.
2. Discuss the regular use of seat belts and children's car seats, obeying the speed limit, and avoiding the use of alcohol and/or drugs while in a vehicle.
3. Assist the family in identifying ways to adapt the home to improve safety and prevent injuries, i.e., poison control, secure electrical cords, fire prevention.
4. Discuss injury prevention adaptations appropriate to the patient's age, disease state, or condition.
5. Identify which community resources promote safety and injury prevention. Provide information regarding key contacts for emergencies, i.e., 911, Poison Control, hospital ER, police.

TE - TESTS

OUTCOME: The patient/family will understand the test(s) to be performed including indications and its impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
3. Explain any necessary preparation for the test, i.e., fasting.
4. Explain the meaning of test results.

TX - TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available based on the specific disease process, test results, and individual preferences.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options.
2. Discuss the treatment plan including lifestyle adaptations, pharmacologic, surgical, and psychosocial aspects of the treatment plan.
3. Discuss the importance of adhering to the treatment plan, including scheduled follow-up.
4. Refer to community resources as appropriate.

MNT—Medical Nutrition Therapy

****For Use By Registered Dieticians Only****

MNT involves the assessment of the nutritional status of patients with a condition, illness, or injury that puts them at risk. Assessment must include review and analysis of medical and diet history, lab values, and anthropometric measurements. MNT is based on assessment, nutrition modalities most appropriate to manage the condition or treat the illness or injury.

MNT plays a key role throughout the continuum of care in all practice settings and phases of the life cycle, from prenatal care to care of the elderly. After nutrition screening identifies those at risk, appropriate MNT leads to improved health outcomes resulting in improved quality of life and cost savings.

The Dietetic Practitioner also referred to, as a Registered Dietitian is the only member of the health care team uniquely qualified to provide MNT.

REGISTERED DIETICIAN: An individual who has completed the minimum of a baccalaureate degree granted by a U.S. regionally accredited college or university or foreign equivalent, has met current minimum academic requirements and complete pre-professional experience, has successfully completed the Registration Examination for Dietitians, and has accrued 75 hours of approved continuing professional education every 5 years.

EDUCATION NEEDS ASSESSMENT CODES

INDIAN HEALTH SERVICE
EDUCATION NEEDS ASSESSMENT CODES

BAR—Barriers to Learning

BAR-BLND BLIND

OUTCOME: The patient states or demonstrates the inability to see, or the patient's inability to see is documented.

STANDARDS:

1. Assess the type and degree of impairment.
2. Determine any adaptive technique or equipment that could accommodate the deficit.
3. Determine if patient can read Braille.

BAR-COGI COGNITIVE IMPAIRMENT

OUTCOME: The patient states or demonstrates an inability to comprehend new information, or, the patient has a documented cognitive impairment problem.

STANDARDS:

1. Assess the type and degree of impairment.
2. Determine adaptive approaches to learning that can be utilize.
3. Plan with patient/family how to reinforce basic information and skills needed for self care.

BAR-DEAF DEAF

OUTCOME: The patient states or demonstrates the inability to hear, or, the patient's inability to hear is documented.

STANDARDS:

1. Assess the type of deafness (cause by such as accident, illness or disease).
2. Determine any adaptive technique or equipment that could accommodate the deficit.
3. Assess Sign language ability and as needed obtain a sign interpreter.
4. Assess ability to lip read, as appropriate, speak directly facing patient and move lips distinctly while speaking.
5. Determine if patient can communicate through writing.

6. Assess and document the on-set of deafness.

BAR-DNRE DOESN'T READ

OUTCOME: The patient states or demonstrates an inability to read, or the patients' inability to read English is documented.

STANDARDS:

1. Ask patient/family if patient reads English.
2. Ask patient/family if patient reads in their primary language. If yes, what language is that?
3. Assess patient's English literacy level (English may be a second language).
4. Provide appropriate written materials.
5. Plan with patient/family about approaches to learning other than reading.

BAR-EMOI EMOTIONAL IMPAIRMENT

OUTCOME: The patient's ability to learn is limited due to an emotional impairment.

STANDARDS:

1. Assess the type and degree of emotional impairment, i.e., mood disorder, psychotic symptoms, acute stress, anxiety, depression.
2. Provide the minimum amount of information needed with simple written information for reinforcement.
3. Refer to Mental Health for assessment and intervention.
4. Plan with patient/family how to reinforce basic information and skills needed for self care.

BAR-FIMS FINE MOTOR SKILLS DEFICIT

OUTCOME: The patient states or demonstrates fine motor skills impairment, like checking blood sugars or measuring medications, or, the patient has a documented fine motor skills deficit.

STANDARDS:

1. Assess the type and degree of impairment.
2. Determine any adaptive technique or equipment that could accommodate the impairment.

BAR-HEAR HARD OF HEARING

OUTCOME: The patient states or demonstrates a problem with hearing, or, the patient's hearing impairment is documented.

STANDARDS:

1. Assess the type and degree of impairment.
2. Determine any adaptive technique or equipment that could accommodate the impairment.
3. Assess ability to lip read, as appropriate, speak directly facing patient and move lips distinctly while speaking.
4. Determine if patient can communicate through writing.

BAR-INTN INTERPRETER NEEDED

OUTCOME: For patients who do not readily understand spoken English, an Interpreter is made available.

STANDARDS:

1. Identify the patient's primary language.
2. Determine their preferred language.
3. As appropriate, obtain an interpreter.

BAR – NONE NO BARRIERS

OUTCOME: The patient/family has no apparent barriers to learning.

STANDARDS:

1. Through interview and /or observation, determine or rule out any barriers that may affect ability to learn.

BAR-STRS SOCIAL STRESSORS

OUTCOME: The patient's ability to learn is limited due to social stressors.

STANDARDS:

1. Assess acute and on-going social stressors (e.g., family separation and conflict, disease, divorce, death, alcohol/substance abuse, domestic violence).
2. Provide the minimum amount of information needed with simple written information for reinforcement. As appropriate defer additional education until crisis is over.
3. Refer to social services or mental health for assessment and/or subsequent referrals.
4. Set-up a date for follow-up assessment as indicated.

BAR-VALU VALUES/BELIEF

OUTCOME: Define what is meant by "value" and "belief." Identify differences in patients and provider's values and beliefs.

Note: There is frequently a discrepancy between what patients value and believe versus what providers think is important (about self-care issues). Initiate open dialogue with the patient. Discuss differences and establish common ground on what the patient is willing to do concerning their health.

Value - A principal, standard, or quality regarded as worthwhile or desirable to the client.

Belief - Something believed or accepted as true by the client.

STANDARDS:

1. Attempt to verbalize the difference(s).
2. Ask questions to clarify patients prospective.
3. Try to identify areas of agreement.
4. Address areas for which there is agreement.
5. Discuss the concept of Locus of Control with patient. Which statement below best describes how the patient sees his/her ability to affect his/her health?
    a. I can control my life/health through my own effort
    b. My doctor/family member/friends control my life/health
    c. I am powerless to affect my life/health

BAR-VISI VISUALLY IMPAIRED

OUTCOME: The patient states or demonstrates difficulty with vision, or the patient's visual impairment is documented.

STANDARDS:

1. Assess the type and degree of impairment.
2. Determine any adaptive technique or equipment that could accommodate the deficit.
3. Determine if patient can communicate through writing.

LP—Learning Preference

LP-DOIT DO/PRACTICE

OUTCOME: The patient/family will understand that by doing or practicing a new skill is their preferred style of learning new information.

STANDARDS:

1. Review the most common styles of adult learning (talk/discussion, watching & doing, group discussion, watching videos, reading)
2. Explain that every individual is unique and will have their own method or preference(s) in how they receive new information.
3. Ask the patient/family, "In what way or ways do you learn best?"

LP-GP SMALL GROUP

OUTCOME: The patient/family will understand that participating in small groups is their preferred style of learning new information.

STANDARDS:

1. Review the most common styles of adult learning (talk/discussion, watching & doing, group discussion, watching videos, reading)
2. Explain that every individual is unique and will have their own method or preference(s) in how they receive new information.
3. Ask the patient/family, "In what way or ways do you learn best?"

LP-READ READ

OUTCOME: The patient/family will understand that reading is their preferred style of learning new information.

STANDARDS:

1. Review the most common styles of adult learning (talk/discussion, watching & doing, group discussion, watching videos, reading)
2. Explain that every individual is unique and will have their own method or preference(s) in how they receive new information.
3. Ask the patient/family, "In what way or ways do you learn best?"

LP-TALK TALK

OUTCOME: The patient/family will understand that talk is their preferred style of learning new information.

STANDARDS:

1. Review the most common styles of adult learning (talk/discussion, watching & doing, group discussion, watching videos, reading)
2. Explain that every individual is unique and will have their own method or preference(s) in how they receive new information.
3. Ask the patient/family, "In what way or ways do you learn best?"

LP-VIDO VIDEO

OUTCOME: The patient/family will understand that viewing videos is their preferred style of learning new information.

STANDARDS:

1. Review the most common styles of adult learning (talk/discussion, watching & doing, group discussion, watching videos, reading)
2. Explain that every individual is unique and will have their own method or preference(s) in how they receive new information.
3. Ask the patient/family, "In what way or ways do you learn best?"

RL—Readiness to Learn

RL-DSTR DISTRACTION

OUTCOME: The patient is unable to learn because of distractions.

STANDARDS:

1. Acknowledge that the environment contains distractions to learning such as noise or young children.
2. Determine any action that could negate or minimize the distraction.
3. Consider deferring educational session until stimuli causing distraction is no longer an issue.

RL – EAGR EAGER TO LEARN

OUTCOME: The patient/family understands or demonstrates a level of eagerness to learn at the beginning of an educational encounter.

STANDARDS:

1. Plan your educational encounter at the most opportunistic and appropriate time during the patient/family's care.
2. Ask the patient/family for their attention to the subject matter.
3. Observe their response to your request or to your presentation of the subject matter.

RL – RCPT RECEPTIVE

OUTCOME: The patient/family understands or demonstrates a receptive level of readiness to learn at the beginning of an educational encounter.

STANDARDS:

1. Plan your educational encounter at the most opportunistic and appropriate time during the patient/family's care.
2. Ask the patient/family for their attention to the subject matter.
3. Observe their response to your request or to your presentation of the subject matter.

RL-PAIN PAIN

OUTCOME: The patient understands or demonstrates through the use of body language a certain level of pain.

STANDARDS:

1. Plan your educational encounter at the most opportunistic and appropriate time during the patient/family's care.
2. Assess their level of pain. Does the patient require pain medication? If so, when was their last dose administered?
3. If appropriate, ask the patient for his/her attention to the subject matter.
4. Observe his/her response to your request or to your presentation of the subject matter.
5. Consider deferring or terminating the educational session if the patient is experiencing a high level of pain or is being medicated for pain.

RL-SVIL SEVERITY OF ILLNESS

OUTCOME: The patient/family will be unable to gain new knowledge due to a condition or severity of illness that would impair or prevent learning.

STANDARDS:

1. Plan your educational encounter at the most opportunistic and appropriate time during the patient/family's care.
2. Assess the severity of their illness. Consider their level or "alertness."
3. Determine if family is available to assist with the patients care. Assess the family's readiness to learn.
4. If appropriate, ask the patient/family for their attention to the subject matter.
5. Observe their response to your request or to your presentation of the subject matter.
6. Consider deferring or terminating the educational session if the patient is experiencing complications from the illness that may distract the family's attention.

RL-UNRC UNRECEPTIVE

OUTCOME: The patient/family understands or demonstrates an unreceptive level of readiness to learn at the beginning of a teaching encounter.

STANDARDS:

1. Plan your educational encounter at the most opportunistic and appropriate time during the patient/family's care.
2. Ask the patient/family for their attention to the subject matter.
3. Observe their response to your request or to your presentation of the subject matter.
4. Ask or suggest to patient/family if they would like to meet at another time for education session.

A

ABD—Abdominal Pain

ABD-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications of abdominal pain and understand that they will return for additional medical care if symptoms of complication occur.

STANDARDS:

1. Explain that some possible complications are acute hemorrhage, sustained hypotension and shock, perforation of a viscous, and infections such as bacteremia.
2. Explain that complications may be prevented with prompt treatment with appropriate therapy.
3. Advise the patient/family to report increasing-pain, persistent fever, bleeding, or altered level of consciousness immediately and seek immediate medical attention.

ABD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand some possible etiologies of abdominal pain.

STANDARDS:

1. Discuss various etiologies for abdominal pain, i.e., appendicitis, diverticulitis, pancreatitis, peritonitis, gastroenteritis, bowel obstruction, ruptured aneurysm, ectopic pregnancy, and inflammatory bowel disease, as appropriate.

ABD-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Explain circumstances/examples that should prompt immediate medical attention.
3. Discuss the procedure for obtaining follow-up appointments.
4. Emphasize that appointments should be kept.

ABD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about abdominal pain.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding abdominal pain.
2. Discuss the content of the patient information literature with the patient/family.

ABD-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and proper use of medication.

STANDARDS:

1. Review the proper use, benefits and common side effects of prescribed medications.
2. Emphasize the importance of maintaining strict participation to the medication regimen.
3. Encourage the patient to carry a list of current medications.

ABD-N NUTRITION

OUTCOME: The patient/family will understand how nutrition might affect abdominal pain.

STANDARDS:

1. Discuss, as appropriate, that some foods might exacerbate abdominal pain.
2. Review this list of foods.

ABD-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the management of abdominal pain.

STANDARD:

1. Discuss, as appropriate, that some foods might exacerbate abdominal pain.
2. Explain that pain medications should be utilized judiciously to prevent the masking of complications.
3. Advise the patient to notify the nurse or provider if pain is not adequately controlled or if there is a sudden change in the nature of the pain.
4. Caution the patient to take pain medications as prescribed, and not to take over-the-counter medications in conjunction with prescribed medications without the recommendation of the provider.
5. Explain that short term use of narcotics may be helpful in pain management as appropriate.
6. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
7. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
8. Explain non-pharmacologic measures that may be helpful with pain control.

ABD-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in the treatment of abdominal pain.

STANDARDS:

1. Discuss that uncontrolled stress may increase alcohol and other drug use and interfere with treatment.
2. Emphasize the importance of seeking professional help as needed to reduce stress.
3. Discuss the various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. Becoming aware of your own reactions to stress
    b. Recognizing and accepting your limits
    c. Talking with people you trust about your worries or problems
    d. Setting realistic and meaningful goals
    e. Getting enough sleep
    f. Making healthy food choices
    g. Regular physical activity
    h. Taking vacations
    i. Practicing meditation
    j. Self-hypnosis
    k. Using positive imagery
    l. Practicing relaxation methods such as deep breathing or progressive muscular relaxation
    m. Spiritual or cultural activities.
4. Provide referrals as appropriate

ABD-TE TESTS

OUTCOME: The patient/family will understand tests to be performed, the potential risks, expected benefits and the risk of non-testing.

STANDARDS:

1. Explain that diagnostic testing may be required to determine the etiology of the pain so appropriate therapy can be initiated.
2. Explain the tests that have been ordered.
3. Explain the necessary benefits and risks of the tests to be performed. Explain the potential risk of refusal of the recommended test(s).
4. Inform the patient of any advance preparation for the test, i.e., nothing by mouth, enemas.

ABD-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be prescribed including the risk and benefits of the treatments or the risk of non-treatment

STANDARDS:

1. List the possible therap(ies) that may be indicated for the treatment of abdominal pain.
2. Briefly explain each of the possible treatment options. Discuss the risk(s) and benefit(s) of the proposed treatment(s).
3. Explain the risk(s) of non-treatment of abdominal pain.

ADM—Admission to Hospital

ADM-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

ADM-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate (when appropriate) proper use of the equipment utilized in patient care.

STANDARDS:

1. Discuss the indications for and benefits of the specific hospital equipment.
2. Discuss the types and features of hospital equipment as appropriate.
3. Instruct the patient regarding necessary involvement and cooperation in the use of equipment, as appropriate.
4. Emphasize safe use of the equipment, i.e., no smoking around O2, use of gloves, electrical cord safety.
5. Discuss proper disposal of associated medical supplies as appropriate.
6. Identify any equipment (i.e., IVs, monitors) utilized for patient care and explain their basic functions and or purposes as appropriate.
7. Emphasize the importance of not tampering with patient care equipment.

ADM-OR ORIENTATION

OUTCOME: The patient/family will have a basic understanding of the unit policies and the immediate environment.

STANDARDS:

1. Provide information regarding the patient's room, including the location of the room, the location and operation of toilet facilities, televisions, radios, etc. and any special information about the room as applicable.
2. Identify the call light or other method for requesting assistance and explain how and when to use it.
3. Explain how the bed controls work.
4. Identify the telephone (if available) and explain how to place calls and how incoming calls will be received. Explain any restrictions on telephone use.
5. Explain the reason for and use of bed side rails in the hospital setting. Discuss the hospital policy regarding side rails as appropriate.
6. Explain the unit visiting policies, including any restrictions to visitation.
7. Explain the hospital smoking policy.
8. Discuss the hospital policy regarding home medications/supplements brought to the hospital.

ADM-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand their rights and responsibilities regarding pain management.

STANDARDS:

1. Explain that it is the patient's right to have their pain assessed and addressed.
2. Explain that pain management is specific to the particular disease process and may be multifaceted.
3. Discuss the patient's responsibility in reporting pain and the effect of pain relief therapies to the provider or Nursing staff.

ADM-POC PLAN OF CARE

OUTCOME: The patient/family will have a basic understanding of the plan of care.

STANDARDS:

1. Explain the basic plan of care for the patient, including the following:
   a. Probable length of stay and discharge planning
   b. Anticipated assessments
   c. Tests to be performed, including laboratory tests, x-rays and others
   d. Therapy to be provided, i.e., medication, physical therapy, dressing changes.
   e. Advance directives. Refer to ADV.
   f. Plan for pain management
   g. Nutrition and dietary plan including restrictions if any
   h. Restraint policy and conditions for release from restraints as applicable
2. Discuss the expected outcome of the plan.

ADM-RI PATIENT RIGHTS AND RESPONSIBILITIES

OUTCOME: The patient/family will have a basic understanding of their rights and responsibilities as well as the process for conflict resolution.

STANDARDS:

1. Review the facility's Bill of Rights and Responsibilities with the patient. Provide a copy of this Bill of Rights to the patient/family.
2. Briefly explain the process for resolving conflicts if the patient/family believe that their rights have been violated.
3. Discuss availability of cultural/spiritual/psychosocial services as appropriate.

ADM-S SAFETY AND ACCIDENT PREVENTION

OUTCOME: The patient/family will understand the necessary precautions to prevent injury during the hospitalization.

STANDARDS:

1. Discuss this patient's plan of care for safety based on the patient-specific risk assessment**. Refer to FALL.**

ADV—Advance Directives

ADV-I INFORMATION

OUTCOME: The patient/family will understand that an Advance Directive is either a Living Will or a Durable Power of Attorney for Health Care.

STANDARDS:

1. Explain that an Advance Directive is a written statement that is completed by the patient in advance of serious illness, regarding how he/she wants medical decisions to be made.
2. Discuss the two most common forms of Advance Directives:
   a. Living Will
   b. Durable Power of Attorney for Health Care.
3. Explain that a patient may have both a living will and a durable power of attorney for health care.

ADV-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive and understand the contents of literature regarding Advance Directives.

STANDARDS:

1. Provide the patient/family with patient information literature.
2. Discuss the content of the patient information literature with the patient/family.

ADV-LW LIVING WILL

OUTCOME: The patient/family will understand that a Living Will is a document that states the type of medical care a patient wants or does not want in the event he/she becomes unable to make decisions for him/herself and is revocable.

STANDARDS:

1. Explain that a Living Will is a document that generally states the kind of medical care a patient wants or does not want in the event he/she becomes unable to make decisions for him/herself.
2. Explain that the Living Will may be changed or revoked at any time the patient wishes.
3. Explain that the Living Will is a legal document and a current copy should be given to the health care provider who cares for the patient.

ADV-POA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

OUTCOME: The patient/family will understand that a Durable Power of Attorney for Health Care is a document that names another person as proxy for health care decisions and is revocable.

STANDARDS:

1. Explain that in most states, a Durable Power of Attorney for Health Care is a signed, dated, witnessed document naming another person, such as a husband, wife, adult child or friend as the agent or proxy to make medical decisions in the event that the patient is unable to make them for him/herself.
2. Explain that instructions can be included regarding ANY treatment/procedure that is wanted or not wanted, such as surgery, a respirator, resuscitative efforts or artificial feeding.
3. Explain that, if the patient changes his/her mind, the Durable Power of Attorney for Health Care can be changed in the same manner it was originated. Explain that a Durable Power of Attorney for Health Care may be prepared by an attorney, but this may not be required in some states.
4. Explain that a Durable Power of Attorney for Health Care pre-empts any other advance directive. Example: The Durable Power of Attorney for Health Care can authorize the person named in the document to make the decision to apply full resuscitation measures even in the presence of a living will if the patient is incapable of making a decision at the time.

ADV-RI PATIENT RIGHTS AND RESPONSIBILITIES

OUTCOME: The patient/family will understand their rights and responsibilities regarding Advance Directives.

STANDARDS:

1. Inform the patient of his/her right to accept, refuse, or withdraw from treatment, and the consequences of such actions.
2. Inform the patient of his/her right to formulate an Advance Directive and appoint a surrogate to make health care decisions on his/her behalf.
3. Explain that an Advance Directive may be changed or canceled by the patient at any time. Any changes should be written, signed and dated in accordance with state law, and copies should be given to the physician and others who received the original document.
4. Explain that it is the patient's responsibility to give a copy of the Advance Directive to the proxy, the health care provider, and to keep a copy in a safe place.

AOD—Alcohol and Other Drugs

AOD-C COMPLICATIONS

OUTCOME: The patient/family will understand how to avoid the complications of alcohol and other drug (AOD) abuse/dependence and develop a plan to slow the progression of the disease by full participation with a prescribed daily program.

STANDARDS:

1. Review the short and long term effects that AODs have on the body.
2. Discuss the progression of use, abuse, and dependence.
3. Review the effects of AOD abuse/dependence on the lifestyle of the individual, the family, and the community.

AOD-CCA CONTINUUM OF CARE

OUTCOME: The patient/family will understand the importance of integrated Continuum of Care in the treatment of AOD use disorders.

STANDARDS:

1. Discuss with patient/family the concept of Continuum of Care in the treatment of AOD use disorders including the pre-treatment, treatment, sobriety maintenance, follow-up, and relapse prevention phases.

2. Provide assistance and advocacy to the patient/family in obtaining integrated Continuum of Care services.

AOD-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)

2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.

3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.

4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.

5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.

6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

AOD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the disease process of AOD abuse and addiction and understand the stages of change.

STANDARDS:

1. Review the current medical information, including physical, psycho-social, and spiritual consequences of the patient's specific AOD abuse/dependency.
2. Discuss the diagnosis of AOD abuse/dependence and provide an opportunity to recognize the disease process of abuse and dependence.
3. Explain the stages of change as applied to the progression of AOD abuse/dependence, i.e., pre-contemplation, contemplation, preparation, action, and maintenance.
4. Discuss the role of the family/support system in the recovery process and an AOD-free lifestyle.
5. Assist the patient/family in developing a plan for healthy and AOD-free lifestyle.

AOD-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity for a healthy and AOD-free life style and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Discuss the benefits of regular physical activity, i.e., reduced stress, weight maintenance, improved self image, and overall wellness.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

AOD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will understand the importance of utilizing available AOD resources to maintain a healthy and AOD-free lifestyle.

STANDARDS:

1. Provide patient/family with appropriate patient information (including literature and/or website addresses) to facilitate understanding and knowledge of AOD issues.
2. Discuss the content of patient information with the patient/family.

AOD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand that alcohol and other drug (AOD) use disorder is a chronic disease, which can be treated.

STANDARDS:

1. Discuss the patient's AOD abuse/dependence and the impact on the patient/family lifestyle.
2. Discuss the patient's perceptions which promote AOD abuse/dependence and mechanisms to modify those perceptions and associated behaviors.
3. Discuss relapse risk of AOD abuse and the need to utilize family, cultural/spiritual and community resources to prevent relapse.
4. Explain that the patient/family and the care team will develop a plan to modify behavior that may precipitate the use of AOD.

AOD-M MEDICATIONS

OUTCOME: The patient/family will understand and fully participate the medication regimen.

STANDARDS:

1. Review the mechanism of action of the prescribed medication.
2. Discuss important or common side-effects of the prescribed medications.
3. Emphasize the importance of taking medications as prescribed, i.e., avoiding overuse, under use or misuse.
4. Review OTC medications (e.g., cough syrup) that contain ETOH/drug additives and the signs/symptoms of intentional/unintentional ingestion.

AOD-N NUTRITION

OUTCOME: The patient/family will understand the importance of nutritionally healthy food choices in the recovery process of AOD-use disorders.

STANDARDS:

1. Review patient's current eating habits and how these habits might be improved with a healthy eating plan.
2. Refer to a registered dietician, when appropriate, for a comprehensive nutritional assessment and meal plan.

AOD-P PREVENTION

OUTCOME: The patient/family will understand the dangers of AOD-use disorders to promote a healthy and AOD- free lifestyle.

STANDARDS:

1. Emphasize awareness of risk factors associated with AOD abuse and dependence, such as experimentation with alcohol and other drugs, binge drinking, and family history of AOD abuse and dependence.
2. Discuss the impact of comorbid conditions and psychosocial stressors on AOD abuse and dependence.
3. Discuss how AOD abuse and dependence adversely affects the patient, family and community.

AOD-PLC PLACEMENT

OUTCOME: The patient/family will understand the recommended level of care/placement as a treatment option for AOD-use disorders.

STANDARDS:

1. Explain the rationale for the recommended placement based on patient/family preference, level of need, court order, safety, eligibility, availability and funding.
2. Explain that the purpose of placement is to improve mental or physical health and to ensure a safe and supportive environment for recovery from AOD-use disorders.
3. Discuss alternative placement or treatment options if recommended placement is declined or unavailable.
4. Discuss patient/family fears and concerns regarding placement and provide advocacy and support during the placement process.

AOD-SCR SCREENING

OUTCOME: The patient/family will understand the process of screening for alcohol and other drug related issues to determine an individual's need for further evaluation and referral.

STANDARDS:

1. Discuss with patient/family the initial reason for the referral for AOD screening and obtain informed consent for the screening as needed.
2. If referring to another provider for screening, explain the referral process for AOD screening and provide assistance with a referral contact as needed.
3. Explain the screening results to the patient/family and the indications for additional referrals or treatment.

AOD-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in the treatment of AOD abuse and dependence.

STANDARDS:

1. Discuss that uncontrolled stress may increase alcohol and other drug use and interfere with treatment.
2. Emphasize the importance of seeking professional help as needed to reduce stress.
3. Discuss the various stress management strategies which may help maintain a healthy AOD-free lifestyle. Examples may include:
    a. Becoming aware of your own reactions to stress
    b. Recognizing and accepting your limits
    c. Talking with people you trust about your worries or problems
    d. Setting realistic and meaningful goals
    e. Getting enough sleep
    f. Making healthy food choices
    g. Regular physical activity
    h. Taking vacations
    i. Practicing meditation
    j. Self-hypnosis
    k. Using positive imagery
    l. Practicing relaxation methods such as deep breathing or progressive muscular relaxation
    m. Spiritual or cultural activities.
4. Provide referrals as appropriate

AOD-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered and any necessary consent as needed.
2. Explain the indications, benefits and risks of the test to be performed, as appropriate, including the consequences of refusal.
3. Explain how the test relates to the course of treatment.
4. Explain the necessary preparation for the test, including appropriate collection or preparation.
5. Explain the meaning of the test results, as appropriate, and the implications for care.

AOD-WL WELLNESS

OUTCOME: The patient/family will understand factors that contribute to wellness.

STANDARDS:

1. Assist the patient/family to identify an AOD-free supportive social network
2. Encourage the patient/family to participate in AOD free family, social, cultural/spiritual and community activities.
3. Discuss the associated health risks with AOD abuse/dependence, i.e., including sexually transmitted infections, unplanned pregnancies, family dysfunction, acute illness, exacerbation of chronic health problems.
4. Explain that AOD use increases the risk of injury, i.e., motor vehicle crashes, falls, assaults.

AL—Allergies

AL-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the physiology of allergic response.

STANDARDS:

1. Review anatomy and physiology as it relates to the patient's disease process and its relationship to the patient's activities of daily living.
2. Explain that allergic response is a collection of symptoms caused by an immune response to substances that do not trigger an immune response in most people, i.e., food allergies; hay fever; allergy to mold, dander, dust, drug allergies.
3. Explain that symptoms vary in severity from person to person.
4. Explain that allergies are common. Heredity, environmental conditions, numbers and types of exposures, emotional factors (stress and emotional upset can increase the sensitivity of the immune system), and many other factors indicate a predisposition to allergies.
5. Explain that allergies may get better or worse over time and that new allergies may appear at any time.

AL-FU FOLLOW-UP

OUTCOME: The patient/family will recognize the importance of routine follow-up as an integral part of health care and maintenance.

STANDARDS:

1. Discuss the importance of routine follow-up by the primary provider, registered dietician and community health services as applicable.
2. Assess the need for any additional follow-up and make the necessary referrals.

AL-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information on allergy reaction.

STANDARDS:

1. Provide the patient/family with written patient information literature on allergies.
2. Discuss the content of the patient of the patient information literature with the patient/family.

AL-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand what lifestyle adaptations are necessary to cope with their allergy(s).

STANDARDS:

1. Assess the patient and family's level of acceptance of the disorder.
2. Review the lifestyle areas that may require adaptations; i.e., diet, physical activity, avoidance of environmental allergens/triggers.
3. Explain that treatment varies with the severity and type of symptom.
4. Emphasize that avoidance of the allergen is the best long-term treatment, particularly with allergic reaction to foods or medications.

AL-M MEDICATION

OUTCOME: The patient/family will understand the goals of drug therapy, the side effects of the medications and the importance of fully participating in the medication regimen.

STANDARDS:

1. Review the mechanism of action for the patient's medication.
2. Discuss the proper use, benefits and common side effects of the patient's prescribed medications. Review signs of possible medication toxicity as indicated.
3. Emphasize the importance of taking medication as prescribed.

AL-N NUTRITION

OUTCOME: The patient/family will understand that a true food allergy is an immune response with a reaction usually within two hours.

STANDARDS:

1. Discuss the importance of avoiding known food allergens. If the allergen is not known, the patient/family can use the elimination diet to discover what is causing the reaction.
2. Encourage the patient/family to keep a food diary to record reactions.
3. Emphasize the importance of reading all food labels. Instruct the patient/family as necessary.
4. Refer to dietitian for assessment of nutritional needs and appropriate treatment as indicated.

AL-TE TESTS

OUTCOME: The patient/family will understand the testi(s) to be performed and possible results.

STANDARDS:

1. Explain that testing may be required to determine if symptoms are an actual allergy or caused by other problems.
2. Explain the testing procedure to the patient/family
3. Discuss the possible results of testing with the patient/family.
4. Emphasize that history is important in diagnosing allergies, including whether the symptoms vary according to the time or the season and possible exposures that involve pets, diet changes or other sources of allergens.
5. Explain allergies may alter the results of some lab tests.

ALZ—Alzheimer's Disease

ALZ-DP DISEASE PROCESS

OUTCOME: The patient/family/caregiver will understand the definition of Alzheimer's and treatment options available specific to the patient's diagnosis.

STANDARD:

1. Explain that Alzheimer's disease is a degenerative brain disorder and is more common in older adults.
2. Explain that Alzheimer's destroys the chemical acetylcholine which is responsible for memory and cognitive skills.
3. Explain that as the disease progresses, nerve cells in several brain areas shrink and die and the brain itself shrinks as the wrinkles along its surface become smoother.
4. Discuss signs and symptoms and usual progression of the disease due to dementia:
    a. Impaired memory and thinking
    b. Disorientation and confusion
    c. Misplacing things
    d. Impaired abstract thinking
    e. Trouble performing familiar tasks
    f. Change in personality and behavior
    g. Poor or decreased judgment
    h. Inability to follow directions
    i. Problems with language or communication
    j. Impaired visual and spatial skills
    k. Loss of motivation or initiative
    l. Loss of normal sleep patterns
    m. Increasing agitation
    n. Irrational violent behavior and lashing out
    o. Late stage loss of ability to swallow
5. Explain that the cause is unknown and nothing can be done to prevent the disease. Encourage a healthy lifestyle and habits that prevent dementia (limit alcohol intake, stop smoking, eat well, exercise).
6. Discuss the importance of maintaining a positive mental attitude.

ALZ-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand the importance of full participation in the treatment plan and follow up.

STANDARDS:

1. Explain the importance of obtaining referrals for contract health services when appropriate.
2. Explain that test(s) required by private outside providers need coordination with Indian Health physicians.
3. Discuss the process for making follow up appointments with internal and external providers.
4. Discuss individual responsibility for seeking and obtaining third party resources.
5. Discuss the importance of keeping follow up appointments and how this may affect outcome.
6. Discuss the possible need for a patient advocate to maintain follow-up activities.

ALZ-HM HOME MANAGEMENT

OUTCOME: The patient/family/caregiver will understand home management of Alzheimer's and develop a plan for implementation, as well as the coordination of home health care services to assure the patient receives comprehensive care.

STANDARDS:

1. Explain the home management techniques necessary based on the status of the patient. Explain that these home management techniques may change as the disease progresses.
2. Discuss ways to minimize confusion:
   a. Limit changes to the physical surroundings.
   b. Encourage full participation to daily routines.
   c. Maintain orientation by reviewing the events of the day, date and time.
   d. Simplify or reword statements.
   e. Label familiar items.
3. Explain that medications must be given as prescribed.
4. Explain the importance of being patient and supportive.
5. Discuss ways of providing a safe environment. **Refer to ALZ-S**.
6. Explain the importance of supervising the patient during bathing and eating. Discourage leaving the patient alone for extended periods.
7. Encourage assistance with activities of daily living as appropriate.
8. Explain the benefits of increased physical activity (strength, endurance, heart fitness, increased energy, improvement in sleep and mood and mental functioning). Advise family/caregiver to consult with a health care provider prior to beginning an exercise program for the patient. Explain that factors such as bone disease, heart condition or balance problems may limit or restrict activities.

ALZ-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family/caregiver will receive written information of Alzheimer's disease and organizations that assist in the care of patients with this disease.

STANDARDS:

1. Provide written information about diagnosis to the patient/family/caregiver.
2. Review the content of patient information literature with the patient/family/caregiver.
3. Advise of any agency or organization that can provide assistance and further education such as support groups.

ALZ-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family/caregiver will understand some of the necessary lifestyle adaptations to improve overall quality of life.

STANDARDS:

1. Discuss lifestyle behaviors that the care giver may be able to help the patient with, such as diet, increased physical activity, and habits related to the risks of the disease.
2. Encourage full participation in the treatment plan.
3. Explain the importance of the patient adapting to a lower risk, healthier lifestyle.
4. Review community resources available to assist the patient in making changes. Refer as appropriate
5. Explain that over the course of the disease, lifestyle adaptations will require frequent adjustments.

ALZ-LW LIVING WILL

OUTCOME: The patient/family will understand the process of making a living will and its role in maintaining a sense of control in the patient's medical care and decisions.

STANDARDS:

1. Explain that in most cases patients with Alzheimer's disease will predictably lose the capacity to make their own decisions and a living-will will be able to express the patient's desires prior to the loss of decision making abilities.
2. Review the option of Advanced Directives/ Living Will with the patient and his/her family. Explain treatment options and answer questions in a manner the patient/family will understand.
3. Refer to appropriate services to assist the patient in making a living will, i.e., Social Services, Clergy, Lawyer.
4. **Refer to ADV**.

ALZ-M MEDICATIONS

OUTCOME: The patient/family/caregiver will understand the choice of medication to be used in the management of Alzheimer's disease.

STANDARDS:

1. Explain the medication regimen to be implemented.
2. Explain the medications to be used including dose, timing, adverse side effects: drug-food, drug-drug interactions
3. Explain that Alzheimer medications are generally well tolerated, although troublesome side effects sometimes occur, i.e., nausea, vomiting, diarrhea, weight loss.
4. Explain that the medications may slow the progression of the disease, but are not a cure.
5. Emphasize that regular reassessment of these medications is crucial.
6. Discuss the importance of consulting a healthcare provider prior to starting new medications, including OTCs, herbal, or traditional remedies.
7. Discuss the use of all medications with your healthcare provider or pharmacist.

ALZ-N NUTRITION

OUTCOME: The patient/family/caregiver will receive nutritional assessment and counseling.

STANDARDS:

1. Assess the patient's current nutritional level and determine an appropriate meal plan.
2. Review normal nutritional needs for optimum health.
3. Explain the importance of serving small, frequent meals and snacks. Encourage offering finger foods that are easy for the patient to handle.
4. Discourage the use of caffeine.
5. Discourage force feeding the patient.
6. Advise serving high calorie foods first. Offer favorite foods.
7. Advise offering a variety of food textures, colors, and temperatures.
8. Discourage foods with little or no nutritional value, i.e., potato chips, candy bars, cola.
9. Encourage walking or light exercise to stimulate appetite.
10. Explain that a the disease progresses the patient will often lose the ability or forget to eat, tube feeding may be an option.
11. Refer to registered dietician as appropriate.

ALZ-PLC PLACEMENT

OUTCOME: The patient/family will understand the recommended level of care/placement as a treatment option.

STANDARDS:

1. Explain the rationale for the recommended placement based on patient/family preference, level of need, involuntary placement, safety, eligibility, availability and funding.
2. Explain that the purpose of placement is to improve mental or physical health and to ensure a safe and supportive environment for continued care.
3. Discuss alternative placement or treatment options if recommended placement is declined or unavailable.
4. Discuss patient/family fears and concerns regarding placement and provide advocacy and support.

ALZ-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family/caregiver will understand the importance of injury prevention and make a plan to implement safety measures.

STANDARDS:

1. Explain the importance of body mechanics in daily living to avoid injury, i.e., proper lifting techniques for lifting the patient.
2. Assist the patient/family/caregiver in identifying ways to adapt the home to improve safety and prevent injuries, i.e., remove throw rugs, install bars in tub/shower, secure electrical cords, install ramps.
3. As appropriate, stress the importance of mobility assistance devices, i.e., canes, walkers, wheel chairs, therapeutic shoes.
4. Discuss the current/potential abuse of alcohol or drugs.
5. Discuss the need to secure medications and other potentially hazardous items.
6. Emphasize the importance of NEVER smoking in bed or never smoking alone.
7. Discuss the potential for elder abuse/neglect (including financial exploitation) and ways to identify abuse/neglect. Refer as appropriate.
8. Explain the need to secure the patient's financial resources as they may be unable to make wise financial decisions.
9. Discuss that as the disease progresses, constant supervision will be necessary.
10. Discuss that patients may wander and alarms on doors and windows may be necessary.

ALZ-SM STRESS MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of stress management in the management of Alzheimer's disease.

STANDARDS:

1. Explain that uncontrolled stress can result in a worsened outcome for the patient, as well as the caregiver.
2. Explain that effective stress management may help improve the patient's sense of health and well-being.
3. Discuss various stress management strategies for the caregiver and the patient, such as maintaining a healthy lifestyle. Some examples may include:
    a. Becoming aware of your own reactions to stress
    b. Recognizing and accepting your limits
    c. Talking with people you trust about your worries and problems
    d. Setting small attainable goals
    e. Getting enough sleep
    f. Maintaining a healthy diet
    g. Exercising regularly
    h. Practicing meditation
    i. Using positive imagery
    j. Spiritual and cultural activities
    k. Utilizing support groups
    l. Utilizing respite care

ALZ-TE TESTS

OUTCOME: The patient/family/caregiver will understand the conditions under which testing is necessary and the specific test(s) to be performed.

STANDARDS:

1. Explain that there is no definitive test for Alzheimer's disease. A definitive diagnosis can only be made after death at autopsy when an examination of the patient's brain may show tell tale signs of changes associated with Alzheimer's.
2. Explain that diagnosis may be made through medical, psychiatric and neurological evaluation. Ruling out other factors for the dementia is necessary to make a diagnosis.
3. Explain that other conditions may mimic Alzheimer's. Some examples are: depression, head injury, certain chemical imbalances, or effects of some medications.

ALZ-TX TREATMENT

OUTCOME: The patient/family/caregiver will understand the focus of the treatment plan will be on the quality of life.

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family/caregiver in the development of the treatment plan.
2. Explain that regular visits to a healthcare provider are a crucial part of the treatment plan and the importance of starting treatment early.
3. Explain that physical activity, good nutrition, and social interaction are important for keeping Alzheimer's patients as functional as possible.
4. Explain the importance of a calm, safe and structured environment.
5. Explain that an appropriate drug regimen can sooth agitation, anxiety, depression, and sleeplessness and may help boost participation in daily activities.
6. Emphasize the importance of reassessing the level of daily functioning, mental status, mood and emotional state of the patient. Discuss the importance of assessing the status of the caregiver(s).
7. Explain that there is no cure and it is important to maintain a positive mental attitude.
8. **Refer to EOL.**

AN—Anemia

AN-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of untreated anemia.

STANDARDS:

1. Explain that failure to fully participate in the prescribed therapy will result in a chronic lack of oxygen, possibly producing signs and symptoms such as chronic or severe fatigue, chronic dyspnea, inability to concentrate, irritability, depression, anxiety, tachycardia and susceptibility to infection.
2. Explain that if tissues don't receive enough oxygen, the body will compensate by increasing heart rate and cardiac output.

AN-DP DISEASE PROCESS

OUTCOME: The patient/family will understand anemia, the specific cause of the patient's anemia and its symptoms.

STANDARDS:

1. Explain that anemia describes a condition in which the concentration of hemoglobin is too low. This may be the result of decreased number of red blood cells, abnormal red blood cells, abnormal hemoglobin molecules or deficiency of iron or other essential chemicals.
2. Explain that the kidneys, bone marrow, hormones and nutrients within the body work in cooperation to maintain the normal red blood cell count.
3. Explain that there are several categories of abnormal conditions that cause anemia: (Discuss those that pertain to this patient)
    a. Lack of dietary iron, vitamin B12, or folic acid
    b. Hereditary disorders of the red blood cells, such as Sickle Cell Anemia or thalassemia
    c. Disorders involving the bone marrow or spleen which inhibit red blood cell formation or destroy red blood cells
    d. Blood loss from the GI tract or other organ as a result of disease or trauma
    e. Kidney disease which may result in decreased production of red blood cells
    f. Thyroid or other hormonal diseases
    g. Cancer and/or the treatment of cancer
    h. Medications
    i. Anemia of chronic disease
4. Explain that when the body's demand for nutrients, including iron, vitamin B12 or folic acid, isn't met, the body's reserves can be rapidly depleted and the nutrients will not be available to produce red blood cells. Fewer circulating red blood cells cause both hemoglobin concentration and the blood's oxygen-carrying capacity to decrease. Consequently, the patient may develop signs and symptoms of anemia.
5. Explain that the body's demand for iron will increase after blood loss, with certain medications and at certain life stages, such as infancy, adolescence and in women during pregnancy.
6. Explain that symptoms of anemia may include fatigue, headache, lightheadedness, tachycardia, anxiety, depression, exertional dyspnea and angina.

AN-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of regular follow-up and will develop a plan to manage their anemia and keep follow-up appointments.

STANDARDS:

1. Emphasize that the treatment plan and full participation to it are the responsibility of the patient.
2. Stress the importance of keeping follow-up appointments and continuing the prescribed therapy even after the condition improves.

AN-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information regarding the specific type of anemia and its treatment.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding the specific type of anemia and its treatment.
2. Discuss the content of the patient information literature with the patient/family.

AN-M MEDICATIONS

OUTCOME: The patient will understand the importance of their prescribed medications and will fully participate in the medication treatment plan.

STANDARDS:

1. Explain that iron replacement therapy is necessary to correct iron-deficiency anemia and oral iron is prescribed most often. It is the safest and most effective treatment. Discuss that iron should be taken as prescribed. Explain that an overdose of iron can be lethal. Emphasize the importance of keeping iron out of the reach of children.
2. Explain that iron injections, which are not as easy, safe or effective, may be necessary if oral iron is not tolerated.
3. Explain that in order to restore total body iron stores a minimum course of iron therapy of three months is usually indicated.
4. Instruct the patient not to take antacids, calcium supplements, dairy products, eggs, whole grain breads, tea or coffee, soy products or wine within 1 hour of taking oral iron. These substances as well as some others interfere with the absorption of iron.
5. Review the proper use, benefits, and common side effects of iron or any other medications prescribed to treat the specific anemia.
6. Review the clinical effects expected with these medications.

AN-N NUTRITION

OUTCOME: The patient/family will understand the role dietary modification plays in treating anemia and develop an appropriate plan for the necessary dietary modifications.

STANDARDS:

1. Explain that diet can be a contributing factor in the disease process if it includes insufficient iron, vitamins and protein to meet the body demands during stages of life when requirements are increased.
2. Explain that diet alone usually cannot treat anemia, but plays an important role in therapy.
3. Encourage the patient to include foods rich in protein, vitamins and iron in the diet.
4. Explain that ascorbic acid (vitamin C) helps the body absorb iron. Instruct the patient to eat plenty of fruits and vegetables and drink fruit juice in place of sodas. If vitamin C supplementation is desirable vitamin C and iron should be taken at the same time.
5. Explain that anorexia and sore mouth often accompany anemia. If this is a problem, suggest frequent, small meals of easily digested food and the avoidance of hot spicy foods.
6. Discuss that pica (the ingestion of dirt or other non-food substances) may be both a symptom and a cause of anemia.

AN-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure(s), as well as the risks, benefits, alternatives to the proposed procedure(s) and associated factors affecting the patient.

STANDARDS:

1. Explain the specific procedure(s) to be performed, including the risks and benefits of performing the procedure and the adverse events which might result from refusal of the procedure.
2. Discuss alternatives to the proposed procedure(s), including expectant management, as appropriate.
3. Discuss the expected patient/family involvement in the care required following the proposed procedure(s).

AN-TE TESTS

OUTCOME: The patient/family will understand the possible tests that may be performed.

STANDARDS:

1. Explain that blood test(s) (i.e., hemoglobin, hematocrit, iron studies, hemoglobin electrophoresis) in conjunction with a thorough history and physical exam are necessary to diagnose anemia.
2. Explain that further tests, including a bone marrow exam, may be necessary to determine the type and cause of the anemia.
3. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
4. Explain that a complete blood count will be necessary to evaluate hemoglobin levels and detect physical/chemical changes in red blood cells or hemoglobin molecules.
5. Explain that periodically during treatment, blood counts must be obtained to assess the patient's degree of recovery.

AN-TX TREATMENTS

OUTCOME: The patient/family will understand the possible treatments that may be performed based on the test results.

STANDARDS:

1. Explain that treatment for anemia depends on the cause and severity.
2. Explain that a treatment plan including a diet of iron-rich foods and iron replacement is necessary to treat iron-deficiency anemia and B12 injections treat pernicious anemia. Other anemias are treated by treating the specific cause of the anemia.
3. Explain that the treatment of severe anemia may include transfusions of red blood cells.
4. Explain that once the hemoglobin levels return to normal, therapy for iron-deficiency anemia should continue for at least 2 months to replenish the body's depleted iron stores.
5. Explain that some anemias require long-term or lifelong treatment and others may not be treatable.

ACC—Anticoagulation

ACC-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of anticoagulation therapy and/or failure to follow medical advice in the use of anticoagulation therapy.

STANDARDS:

1. Explain that failure to follow medical advice in anticoagulation therapy may result in a blood clot or uncontrollable bleeding.
2. Explain that even with correct dosing, disease processes that cause problems with clotting may have devastating outcomes including stroke, uncontrollable bleeding, deep venous thrombosis or death, etc.
3. Emphasize the importance of immediately seeking medical attention for unexplained bruising or bleeding, pain in the legs or chest, severe headache, confusion, dizziness or changes in vision, etc.

ACC–DP DISEASE PROCESS

OUTCOMES: The patient will understand what causes a blood clot, the risks of developing blood clots, and methods to prevent the formation of blood clots.

STANDARDS:

1. Review the causative factors as appropriate to the patient.
2. Review lifestyle factors which may put the patient at risk of developing a blood clot.
3. Discuss the patient's specific condition, including anatomy and pathophysiology as appropriate.
4. Discuss the signs and symptoms of active clotting or over-anticoagulation.

ACC–FU FOLLOW-UP

OUTCOMES: The patient/family will understand the importance of follow-up and make a plan to make and keep the follow-up appointments.

STANDARDS:

1. Emphasize the importance of follow-up care to adjustment medications and prevent complications.
2. Encourage full participation in the treatment plan and acceptance of the diagnosis.
3. Explain the procedure for obtaining follow-up appointments.

ACC–HM HOME MANAGEMENT

OUTCOMES: The patient/family will understand what lifestyle adaptations are necessary to cope with the patient's specific disorder and how diet and activity will interact with anticoagulation therapy.

STANDARDS:

1. Assess the patient/family's level of acceptance of the disorder.
2. Emphasize the importance of avoiding dangerous or hazardous activities while receiving anticoagulation therapy.
3. Review the areas that may require adaptations, i.e., diet and physical activity.

ACC–L LITERATURE

OUTCOMES: the patient/family will receive written information regarding anticoagulation therapy.

STANDARDS:

1. Provide the patient/family with written patient information literature on anticoagulation therapy.
2. Discuss the content of the patient information literature with the patient/family.

ACC–LA LIFESTYLE ADAPTATIONS

OUTCOMES: The patient/family will understand what lifestyle adaptations are necessary to cope with the patient's specific disorder and how diet and activity will interact with anticoagulation therapy.

STANDARDS:

1. Assess the patient/family's level of acceptance of the disorder.
2. Emphasize the importance of avoiding dangerous or hazardous activities while receiving anticoagulation therapy.
3. Review the areas that may require adaptations, i.e., diet and physical activity.

ACC–M MEDICATIONS

OUTCOMES: The patient will understand the goal of medication therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Review the patient's medication. Reinforce the importance of knowing the medication, dose, and dosing interval of medications.
2. Review common and important side effects, signs of toxicity, and drug/drug and drug/food interactions of medications.
3. Explain that some over-the-counter medications or herbal products can alter the effect of the anticoagulation therapy.
4. Emphasize that a health care provider must be consulted prior to starting any new medications (prescription, OTC, or herbal) while receiving anticoagulation therapy.

ACC–N NUTRITION

OUTCOMES: The patient/family will understand the effect of various foods in relation to their anticoagulation therapy.

STANDARDS:

1. Explain the importance of a consistent diet while receiving anticoagulation therapy.
2. Explain how various foods may interact with the patient's medication to alter coagulation.
3. Explain how various foods may alter the results of laboratory tests.

ACC–S SAFETY AND INJURY PREVENTION

OUTCOMES: The patient/family will understand the risks associated with anticoagulation therapy and the measures that must be taken to avoid serious adverse effects.

STANDARDS:

1. Discuss the risks associated with anticoagulation therapy, i.e., bleeding, stroke, adverse drug reactions.
2. Inform the patient/family to seek immediate medical attention in the event of an adverse reaction resulting from anticoagulation therapy.
3. Discuss the importance of informing all health care workers of anticoagulation therapy.
4. Emphasize the importance of avoiding dangerous or hazardous activities while receiving anticoagulation therapy to prevent the risk of serious adverse effects (bleeding).

ACC-TE TESTS

OUTCOME: The patient/family will understand the test(s) proposed, the risk(s) and benefit(s) of the test(s) and the risk/benefit of non-performance of the testing. The patient/family will further understand that it is extremely important to have regular testing while on anticoagulation therapy.

STANDARDS:

1. Discuss the importance of regular laboratory testing in the management of anticoagulation therapy. Explain that this testing is necessary to appropriately adjust the medication as applicable.
2. Explain the risk/benefit ratio of testing vs. non-testing.

ASM—Asthma

ASM-C COMPLICATIONS

OUTCOME: The patient/family will understand how to prevent complications of asthma.

STANDARDS:

1. Discuss that the most common complications of asthma are exacerbation or infection. These complications often result from failure to fully participate with treatment regimens (i.e., medications, peak flows) or from exposure to environmental triggers or infections.
2. Emphasize early medical intervention for minor URIs, fever, cough, and shortness of breath can reduce the risk of complications, hospitalizations, E.R. visits, and chronic complications of the disease.
3. Stress the importance of fully participating in the treatment plan. Explain that failure to fully participate with the treatment plan may result in permanent scarring of the lungs.

ASM-DP DISEASE PROCESS

OUTCOME: The patient will understand the etiology and pathophysiology of asthma.

STANDARDS:

1. Review the anatomy and physiology of the respiratory system.
2. Discuss common triggers of asthma attacks, i.e., smoke, animal dander, cold air, exercise.
3. Explain that asthma is a chronic inflammatory disease and must be treated on a long-term ongoing basis.
4. Explain the various aspects of an asthma attack, including airway inflammation (swelling), mucus production, and constriction of airway muscles.
5. Explain that asthma is an atopic condition and may occur in combination with other atopic illnesses, i.e., nasal allergy. Explain that control of these concomitant illnesses may be necessary to control the asthma.

ASM-EQ EQUIPMENT

OUTCOME: Refer to outcomes for **ASM-NEB**, **PF**, **MDI**, and **SPA**.

STANDARDS:

1. **Refer to ASM-NEB, PF, MDI, and SPA.**

ASM-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in this patient's disease process and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
2. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
3. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
4. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
5. Discuss medical clearance issues for physical activity.
6. Discuss that exercise is a common trigger of asthma attacks and that inhalers or other medications may be necessary before engaging in athletic activities. Explain that for persons with severe asthma, exercise may need to be limited until the asthma is under better control.

ASM-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of regular follow-up and will strive to keep scheduled appointments.

STANDARDS:

1. Discuss the importance of regular follow-up care in the prevention of complications and adjustment of medications.
2. Encourage full participation with the treatment plan. Assess the patient's understanding of the treatment plan and acceptance of the diagnosis.
3. Provide positive reinforcement for areas of achievement.
4. Refer to community resources as appropriate.
5. Emphasize the importance of consistent peak flow measurement and charting of these measurements. Emphasize the importance of bringing peak flow charts to clinic visits as they assist in management of the asthma.

ASM-HM HOME MANAGEMENT

OUTCOME: The patient and/or family will understand the home management of their disease process and make a plan for implementation.

STANDARDS:

1. Discuss home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer emergency room visits and fewer hospitalizations.
3. Emphasize the importance of consistent peak flow measurement and charting of these measurements. Emphasize the importance of bringing peak flow charts to clinic visits as they assist in management of the asthma.
4. Emphasize the importance of correctly using inhalers and other medications as prescribed.
5. Identify and avoid environmental triggers (i.e., cigarette smoke, stress, environmental smoke, pollen, mold, dust, roaches, insecticides, paint fumes, perfumes, animal dander, cold air, sulfites, aspirin) as appropriate for the patient.

ASM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about asthma.

STANDARDS:

1. Provide the patient/family with written patient information literature on asthma.
2. Discuss the content of the patient information literature with the patient/family.

ASM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will strive to make the lifestyle adaptations necessary to prevent complications of asthma and prolong life.

STANDARDS:

1. Discuss which lifestyle changes the patient has the ability to change: cessation of smoking, dietary modifications, weight control, treatment participation, and exercise.
2. Re-emphasize how complications of asthma can be reduced or eliminated by such changes.
3. Review the community resources available to help the patient in making such lifestyle changes.
4. Identify and avoid environmental triggers (i.e., cigarette smoke, stress, environmental smoke, pollen, mold, dust, roaches, insecticides, paint fumes, perfumes, animal dander, cold air, sulfites, aspirin) as appropriate for the patient.

ASM-M MEDICATIONS

OUTCOME: The patient and/or family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed medication regimen.

STANDARDS:

1. Review the patient's medications. Reinforce the importance of knowing the drug, dose, and dosing interval of medications.
2. Review common side effects, signs of toxicity, and drug interactions of medication(s).
3. Discuss the difference between fast relief and long-term control metered dose inhalers.
4. Explain the difference between maintenance and rescue drugs.
5. Emphasize full participation and explain how effective use of medications can facilitate a more active life style for the asthma patient.
6. Emphasize the importance of consulting with a health care provider before using any OTC medication.

ASM-MDI METERED-DOSE INHALERS

OUTCOME: The patient will be able to demonstrate correct technique for use of MDIs and understand their role in the management of asthma.

STANDARDS:

1. Instruct and demonstrate steps for standard or alternate use procedure for metered-dose inhalers and ways to clean and store the unit properly.
2. Review the importance of using consistent inhalation technique. **Refer to ASM-SPA.**

ASM-N NUTRITION

OUTCOME: The patient/family will understand nutritional factors that may effect or trigger asthma.

STANDARDS:

1. Discuss that some foods may affect asthma. Common triggers are milk products, egg products, wheat products, and other.
2. Refer to a registered dietician as appropriate.

ASM-NEB NEBULIZER

OUTCOME: The patient will be able to demonstrate effective use of the nebulizer device, discuss proper care and cleaning of the system, and describe its place in the care plan.

STANDARDS:

1. Describe proper use of the nebulizer including preparation of the inhalation mixture, inhalation technique, and care of equipment.
2. Discuss the nebulizer treatment as it relates to the medication regimen.

ASM-PF PEAK-FLOW METER

OUTCOME: The patient will be able to demonstrate correct use of the peak-flow meter and explain how its regular use can help achieve a more active lifestyle.

STANDARDS:

1. Discuss use and care of the peak flow meter as a tool for measurement of peak expiratory flow rate (PEFR) and degree of airway obstruction. Discuss peak flow zones in management of airway disease.
2. Explain how monitoring measurement of PEFR can provide an objective way to determine current respiratory function.
3. Emphasize how a regular monitoring schedule can help determine when emergency care is needed, prevent exacerbations through early intervention, and facilitate a more active lifestyle.
4. Explain that charting of peak flow values daily and bringing the chart to clinic visits will assist the provider in assessing the patient's current asthma control and in adjusting medications accordingly.

ASM-SHS SECOND-HAND SMOKE

OUTCOME: Provide the patient and/or family with an understanding of the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. Smoldering cigarette, cigar, or pipe
   b. Smoke that is exhaled from active smoker
   c. Smoke residue on clothing, upholstery, carpets or walls
2. Discuss harmful substances in smoke
   a. Nicotine
   b. Benzene
   c. Carbon monoxide
   d. Many other carcinogens (cancer causing substances)
3. Explain the increased risk of illness in the asthma patient when exposed to cigarette smoke either directly or via second-hand smoke.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the asthma patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage smoking cessation or at least never smoking in the home or car.

ASM-SPA SPACERS

OUTCOME: The patient will be able to demonstrate the correct use of spacers and understand their importance in delivery of medications.

STANDARDS:

1. Instruct and demonstrate proper technique for spacer use.
2. Discuss proper care and cleaning of spacers.
3. Explain how spacers improve the delivery of inhaled medications.

ASM-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Discuss the necessity, benefits and risks of the test to be performed, as appropriate, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Discuss the meaning of the test results, as appropriate.

ASM-TO TOBACCO (SMOKING)

OUTCOME: The patient and/or family will understand the dangers of smoking in the asthma patient and develop a plan to cut back or stop smoking.

STANDARDS:

1. Explain the increased risk of illness in the asthma patient when exposed to cigarette smoke.
2. Encourage smoking cessation. If the patient is unwilling to stop smoking, emphasize the importance of cutting back on the number of cigarettes smoked in an effort to quit or minimize increased risk of illness or hospitalization.
3. **Refer to TO**.

B

BELL—Bell's Palsy

BELL-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand the anatomy and physiology as it relates to Bell's palsy.

STANDARDS:

1. Explain that Bell's palsy is a form of facial paralysis resulting from damage or disease of the 7th (facial) cranial nerve.
2. Explain that the mechanism of Bell's palsy involves swelling of the nerve due to immune or viral disease, with ischemia and compression of the nerve in the confines of the temporal bone.

BELL-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of Bell's Palsy.

STANDARDS:

1. Explain that damage to the cornea can occur if the eyelid does not close: blinking is impaired or lacrimation does not occur.
2. Discuss that the frequent use of artificial tears or saline drops in the eyes may be helpful.
3. Explain that a lubricant eye ointment is most effective.
4. Explain that the healthcare provider may recommend the use of tape or an eye patch to help close the eye.

BELL-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the possible causes and disease process of Bell's Palsy.

STANDARDS:

1. Explain that Bell's palsy can strike almost anyone at any age, but it is less common before age 15 and after age 60. Explain that it is more common in persons with diabetes, influenza, a cold or upper respiratory ailment, and pregnancy.
2. Explain that the common cold sore virus, herpes simplex, and other herpes viruses cause many cases of Bell's palsy, but Bell's palsy can also be caused by other infections especially tick fevers.
3. Explain that pain behind the ear may precede facial weakness and that weakness may progress to complete unilateral facial paralysis within hours. This paralysis may cause a drooping eyelid, inability to blink, drooping mouth, drooling, dryness of the eye or mouth, impaired taste, and excessive tearing. Explain that in severe cases the eye may not close and that salivation, taste and lacrimation may be affected.
4. Discuss that the prognosis for Bell's palsy is generally very good. Explain that about 80 % recover completely within 3 months, but that for some the symptoms may last longer and may never completely disappear. Explain that the recovery for complete paralysis takes longer and that there is an increased incidence of residual symptoms.
5. Discuss that during the recovery period regrowth of nerve fibers may result in tearing while eating and unexpected muscle contractions during voluntary facial movements.

BELL-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of regular follow-up and will develop a plan to manage the Bell's palsy and keep follow-up appointments.

STANDARDS:

1. Emphasize that full participation in the treatment plan is the responsibility of the patient.
2. Review the treatment plan with the patient/family, emphasizing the need for keeping appointments, taking medications as prescribed, and fully participating with the physical therapy plan.
3. Review the symptoms that should be reported and measures to take if they occur.
4. Stress the importance of keeping follow-up appointments and continuing the prescribed therapy as long as recommended by the healthcare provider.

BELL-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information regarding Bell's palsy and its treatment.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding Bell's palsy and its treatment.
2. Discuss the content of the patient information literature with the patient/family.

BELL-M MEDICATIONS

OUTCOME: The patient will understand their medications and the importance of taking them as prescribed.

STANDARDS:

1. Explain that medications may reduce inflammation of the nerve and may relieve pain.
2. Discuss the proper use, benefits, common side effects and interactions of the prescribed medication(s). Review signs of possible toxicity and appropriate follow up as indicated.
3. Emphasize the importance of taking medications as prescribed.
4. Discuss the mechanism of action of the medication as needed.
5. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter or herbal medications.
6. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies to the provider.

BELL-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that usually pain from Bell's palsy is transient and controllable with mild analgesics.
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain the use of heat and cold in the relief of pain as appropriate.
4. Explain that the use of non-pharmacologic measures, such as imagery may be helpful with pain control.

BELL-TE TESTS

OUTCOME: The patient/family will understand the tests that may be performed, including indications and impact on further care.

STANDARDS:

1. Explain that chest and skull x-rays, CT and/or MRI scans may be necessary to rule out other serious causes of facial paralysis.
2. Explain that tests for tick fever may also help diagnose the cause of the palsy and may be necessary to guide appropriate treatment.
3. Explain that nerve conduction studies and electromyography may be ordered to determine the extent of the nerve damage.
4. Explain the specific test ordered.
5. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
6. Explain any necessary preparation for the test ordered.
7. Explain the meaning of the test results, as appropriate.

BELL-TX TREATMENTS

OUTCOME: The patient/family will understand the possible treatments that may be performed.

STANDARDS:

1. Explain that the patient and medical team will make the treatment plan after reviewing available options.
2. Discuss the treatment plan, including lifestyle adaptations, pharmacologic, and psychosocial aspects.
3. Discuss the importance of fully participating with the treatment plan, including scheduled follow-up.

BWP—Biological Weapons

Information obtained from USAMRIID's Medical Management of Biological Casualties Handbook, Fourth Edition, February 2001

The information contained in these codes can be used to guide patient education and should not be relied upon as a source for guiding therapeutic decisions. For all questions related to treatment and vaccinations, please contact the most recent update of the USAMRIID's Medical Management of Biological Casualties Handbook, your state guidelines, and/or your hospital's policy and procedures.

BWP-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential consequences of exposure to a biological weapon and will understand the effects, consequences possible as a result of this exposure, failure to manage the exposure, or as a result of treatment.

STANDARDS:

1. Discuss common or significant complications that may occur after exposure to biological weapons as appropriate.
2. Discuss common or significant complications which may be prevented by fully participating in the treatment regimen.
3. Discuss common or significant complications which may result from treatment(s).

BWP-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

BWP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the expected course of disease resulting from exposure to the biological weapon.

STANDARDS:

1. Discuss the current information about the suspected biological weapon including the time-course, clinical features, and pathophysiology.
2. Discuss the signs/symptoms and usual progression of the suspected biological weapon.
    a. **Anthrax:** The incubation period is generally 1-6 days, although longer periods have been noted. Fever, malaise, fatigue, cough and mild chest discomfort progresses to severe respiratory distress with dyspnea, diaphoresis, stridor, cyanosis, and shock. Death typically occurs within 24-36 hours after onset of severe symptoms. Anthrax presents as three somewhat distinct clinical syndromes in humans: cutaneous, inhalational, and gastrointestinal disease. The cutaneous form (also referred to as a malignant pustule) occurs most frequently on the hands and forearms of persons working with infected livestock. It begins as a papule followed by formation of a fluid-filled vesicle. The vesicle typically dries and forms a coal-black scab (eschar), hence the term anthrax (from the Greek for coal).

This local infection can occasionally disseminate into a fatal systemic infection. Gastrointestinal anthrax is rare in humans, and is contracted by the ingestion of insufficiently cooked meat from infected animals. Endemic inhalational anthrax, known as Woolsorters' disease, is also a rare infection contracted by inhalation of the spores. It occurs mainly among workers in an industrial

b. **Brucellosis:** Brucellosis has a low mortality rate (5% of untreated cases), with rare deaths caused by endocarditis or meningitis. Also, given that the disease has a relatively long and variable incubation period (5-60 days), and that many naturally occurring infections are asymptomatic, its usefulness as a weapon may be diminished. Large aerosol doses, however, may shorten the incubation period and increase the clinical attack rate, and the disease is relatively prolonged, incapacitating, and disabling in its natural form. Brucellosis, also known as "undulant fever", typically presents as a nonspecific febrile illness resembling influenza. Fever, headache, myalgias, arthralgias, back pain, sweats, chills, generalized weakness, and malaise are common complaints. Cough and pleuritic chest pain occurs in up to twenty percent of cases, but acute pneumonitis is unusual, and pulmonary symptoms may not correlate with radiographic findings. The chest x-ray is often normal, but may show lung abscesses, single or miliary nodules, bronchopneumonia, enlarged hilar lymph nodes, and pleural effusions. Gastrointestinal symptoms (anorexia, nausea, vomiting, diarrhea and constipation) occur in up to 70 percent of adult cases, but less frequently in children. Ileitis, colitis, and granulomatous or mononuclear infiltrative hepatitis may occur, with hepato- and splenomegaly present in 45-63 percent of cases. Lumbar pain and tenderness can occur in up to 60% of brucellosis cases and are sometimes due to various osteoarticular infections of the axial skeleton. Vertebral osteomyelitis, intervertebral disc space infection, paravertebral abscess, and sacroiliac infection occur in a minority of cases, but may be a cause of chronic symptoms. Consequently, persistent fever following therapy or the prolonged presence of significant musculoskeletal complaints should prompt CT or MR imaging. 99m Technetium and 67 Gallium scans are also reasonably sensitive means for detecting sacroiliitis and other axial skeletal infections. Joint involvement in brucellosis may vary from pain to joint immobility and effusion. While the sacroiliac joints are most commonly involved, peripheral joints (notably, hips, knees, and ankles) may also be affected. Meningitis complicates a small minority of brucellosis cases, and encephalitis, peripheral neuropathy, radiculoneuropathy and meningovascular syndromes have also been observed in rare instances. Behavioral disturbances and psychoses appear to occur out of proportion to the height of fever, or to the amount of overt CNS disease. This raises questions about an ill-defined neurotoxic component of brucellosis.

c. **Glanders and Melioidosis:** Incubation period ranges from 10-14 days after inhalation. Onset of symptoms may be abrupt or gradual. Inhalational

exposure produces fever (common in excess of 102 F), rigors, sweats, myalgias, headache, pleuritic chest pain, cervical adenopathy, hepatosplenomegaly, and generalized papular / pustular eruptions. Acute pulmonary disease can progress and result in bacteremia and acute septicemic disease. Both diseases are almost always fatal without treatment. Both glanders and melioidosis may occur in an acute localized form, as an acute pulmonary infection, or as an acute fulminant, rapidly fatal, sepsis. Combinations of these syndromes may occur in human cases. Also, melioidosis may remain asymptomatic after initial acquisition, and remain quiescent for decades. However, these patients may present with active melioidosis years later, often associated with an immune-compromising state. Aerosol infection produced by a BW weapon containing either B. mallei or B. pseudomallei could produce any of these syndromes. The incubation period ranges from 10- 14 days, depending on the inhaled dose and agent virulence. The septicemic form begins suddenly with fever, rigors, sweats, myalgias, pleuritic chest pain, granulomatous or necrotizing lesions, generalized erythroderma, jaundice, photophobia, lacrimation, and diarrhea. Physical examination may reveal fever, tachycardia, cervical adenopathy and mild hepatomegaly or splenomegaly. Blood cultures are usually negative until the patient is moribund. Mild leukocytosis with a shift to the left or leukopenia may occur. The pulmonary form may follow inhalation or arise by hematogenous spread. Systemic symptoms as described for the septicemic form occur. Chest radiographs may show miliary nodules (0.5-1.0 cm) and/or a bilateral bronchopneumonia, segmental, or lobar pneumonia, consolidation, and cavitating lung lesions. Acute infection of the oral, nasal, and/ or conjunctival mucosa can cause mucopurulent, blood-streaked discharge from the nose, associated with septal and turbinate nodules and ulcerations. If systemic invasion occurs from mucosal or cutaneous lesions then a papular and / or pustular rash may occur that can be mistaken for smallpox (another possible BW agent). Evidence of dissemination of these infections includes the presence of skin pustules, abscesses of internal organs, such as liver and spleen, and multiple pulmonary lesions. This form carries a high mortality, and most patients develop rapidly progressive septic shock. The chronic form is unlikely to be present within 14 days after a BW aerosol attack. It is characterized by cutaneous and intramuscular abscesses on the legs and arms. These lesions are associated with enlargement and induration of the regional lymph channels and nodes. The chronic form may be asymptomatic, especially with melioidosis. There have been cases associated with the development of steomyelitis, brain abscess, and meningitis.

d. **Plague:** Pneumonic plague begins after an incubation period of 1-6 days, with high fever, chills, headache, malaise, followed by cough (often with hemoptysis), progressing rapidly to dyspnea, stridor, cyanosis, and death. Gastrointestinal symptoms are often present. Death results from respiratory failure, circulatory collapse, and a bleeding diathesis. Bubonic

plague, featuring high fever, malaise, and painful lymph nodes (buboes) may progress spontaneously to the septicemic form (septic shock, thrombosis, DIC) or to the pneumonic form. Plague normally appears in three forms in man: bubonic, septicemic, and pneumonic. The bubonic form begins after an incubation period of 2-10 days, with acute and fulminant onset of nonspecific symptoms, including high fever, malaise, headache, myalgias, and sometimes nausea and vomiting. Up to half of patients will have abdominal pain. Simultaneous with or shortly after the onset of these nonspecific symptoms, the bubo develops – a swollen, very painful, infected lymph node. Buboes are normally seen in the femoral or inguinal lymph nodes as the legs are the most commonly flea-bitten part of the adult human body. The liver and spleen are often tender and palpable. One quarter of patients will have various types of skin lesions: a pustule, vesicle, eschar or papule (containing leukocytes and bacteria) in the lymphatic drainage of the bubo, and presumably representing the site of the inoculating flea bite. Secondary septicemia is common, as greater than 80 percent of blood cultures are positive for the organism in patients with bubonic plague. However, only about a quarter of bubonic plague patients progress to clinical septicemia. In those that do progress to secondary septicemia, as well as those presenting septicemic but without lymphadenopathy (primary septicemia), the symptoms are similar to other Gram-negative septicemias: high fever, chills, malaise, hypotension, nausea, vomiting, and diarrhea. However, plague septicemia can also produce thromboses in the acral vessels, with necrosis and gangrene, and DIC. Black necrotic appendages and more proximal purpuric lesions caused by endotoxemia are often present. Organisms can spread to the central nervous system, lungs, and elsewhere. Plague meningitis occurs in about 6% of septicemic and pneumonic cases. Pneumonic plague is an infection of the lungs due to either inhalation of the organisms (primary pneumonic plague), or spread to the lungs from septicemia (secondary pneumonic plague). After an incubation period varying from 1 to 6 days for primary pneumonic plague (usually 2-4 days, and presumably dose-dependent), onset is acute and often fulminant. The first signs of illness include high fever, chills, headache, malaise, and myalgias, followed within 24 hours by a cough with bloody sputum. Although bloody sputum is characteristic, it can sometimes be watery or, less commonly, purulent. Gastrointestinal symptoms, including nausea, vomiting, diarrhea, and abdominal pain, may be present. Rarely, a cervical bubo might result from an inhalational exposure. The chest X-ray findings are variable, but most commonly reveal bilateral infiltrates, which may be patchy or consolidated. The pneumonia progresses rapidly, resulting in dyspnea, stridor, and cyanosis. The disease terminates with respiratory failure, and circulatory collapse. Nonspecific laboratory findings include a leukocytosis, with a total WBC count up to 20,000 cells with increased bands, and greater than 80 percent polymorphonuclear cells. One also often finds increased fibrin split products in the blood indicative of a low-

grade DIC. The BUN, creatinine, ALT, AST, and bilirubin may also be elevated, consistent with multi-organ failure. In man, the mortality of untreated bubonic plague is approximately 60 percent (reduced to <5% with prompt effective therapy), whereas in untreated pneumonic plague the mortality rate is nearly 100 percent, and survival is unlikely if treatment is delayed beyond 18 hours of infection. In the U.S. in the past 50 years, 4 of the 7 pneumonic plague patients (57%) died. Recent data from the ongoing Madagascar epidemic, which began in 1989, corroborate that figure; the mortality associated with respiratory involvement was 57%, while that for bubonic plague was 15%.

e. **Q-Fever:** Fever, cough, and pleuritic chest pain may occur as early as ten days after exposure. Patients are not generally critically ill, and the illness lasts from 2 days to 2 weeks. Following the usual incubation period of 2-14 days, Q fever generally occurs as a self-limiting febrile illness lasting 2 days to 2 weeks. The incubation period varies according to the numbers of organisms inhaled, with longer periods between exposure and illness with lower numbers of inhaled organisms (up to forty days in some cases). The disease generally presents as an acute non-differentiated febrile illness, with headaches, fatigue, and myalgias as prominent symptoms. Physical examination of the chest is usually normal. Pneumonia, manifested by an abnormal chest x-ray, occurs in half of all patients, but only around half of these, or 28 percent of patients, will have a cough (usually non-productive) or rales. Pleuritic chest pain occurs in about one-fourth of patients with Q fever pneumonia. Chest radiograph abnormalities, when present, are patchy infiltrates that may resemble viral or mycoplasma pneumonia. Rounded opacities and adenopathy have also been described. Approximately 33 percent of Q fever cases will develop acute hepatitis. This can present with fever and abnormal liver function tests with the absence of pulmonary signs and symptoms. Uncommon complications include chronic hepatitis, culture-negative endocarditis, aseptic meningitis, encephalitis and osteomyelitis. Most patients who develop endocarditis have pre-existing valvular heart disease.

f. **Tularemia:** Ulceroglandular tularemia presents with a local ulcer and regional lymphadenopathy, fever, chills, headache and malaise. Typhoidal tularemia presents with fever, headache, malaise, substernal discomfort, prostration, weight loss and a non-productive cough. After an incubation period varying from 1-21 days (average 3-5 days), presumably dependent upon the dose of organisms, onset is usually acute. Tularemia typically appears in one of six forms in man depending upon the route of inoculation: typhoidal, ulceroglandular, glandular, oculoglandular, oropharyngeal, and pneumonic tularemia. In humans, as few as 10 to 50 organisms will cause disease if inhaled or injected intradermally, whereas approximately 10 organisms are required with oral challenge. Typhoidal tularemia (5-15 percent of naturally acquired cases) occurs mainly after inhalation of infectious aerosols, but can occur after intradermal or gastrointestinal challenge. F. tularensis would presumably be most likely

delivered by aerosol in a BW attack and would primarily cause typhoidal tularemia. It manifests as fever, prostration, and weight loss, but unlike most other forms of the disease, presents without lymphadenopathy. Pneumonia may be severe and fulminant and can be associated with any form of tularemia (30% of ulceroglandular cases), but it is most common in typhoidal tularemia (80% of cases). Respiratory symptoms, substernal discomfort, and a cough (productive and non-productive) may also be present. Case fatality rates following a BW attack may be greater than the 1-3 % seen with appropriately treated natural disease. Case fatality rates are about 35% in untreated naturally acquired typhoidal cases. Ulceroglandular tularemia (75-85 percent of cases) is most often acquired through inoculation of the skin or mucous membranes with blood or tissue fluids of infected animals. It is characterized by fever, chills, headache, malaise, an ulcerated skin lesion, and painful regional lymphadenopathy. The skin lesion is usually located on the fingers or hand where contact occurs. Glandular tularemia (5-10 percent of cases) results in fever and tender lymphadenopathy but no skin ulcer. Oculoglandular tularemia (1-2 percent of cases) occurs after inoculation of the conjunctivae by contaminated hands, splattering of infected tissue fluids, or by aerosols. Patients have unilateral, painful, purulent conjunctivitis with preauricular or cervical lymphadenopathy. Chemosis, periorbital edema, and small nodular lesions or ulcerations of the palpebral conjunctiva are noted in some patients. Oropharyngeal tularemia refers to primary ulceroglandular disease confined to the throat. It produces an acute exudative or membranous pharyngotonsillitis with cervical lymphadenopathy. Pneumonic tularemia is a severe atypical pneumonia that may be fulminant and with a high case fatality rate if untreated. It can be primary following inhalation of organisms or secondary following hematogenous / septicemic spread. It is seen in 30-80 percent of the typhoidal cases and in 10-15 percent of the ulceroglandular cases. The case fatality rate without treatment is approximately 5 percent for the ulceroglandular form and 35 percent for the typhoidal form. All ages are susceptible, and recovery is generally followed by permanent immunity.

g. **Smallpox:** Clinical manifestations begin acutely with malaise, fever, rigors, vomiting, headache, and backache. 2-3 days later lesions appear which quickly progress from macules to papules, and eventually to pustular vesicles. They are more abundant on the extremities and face, and develop synchronously. The incubation period of smallpox averaged 12 days, although it could range from 7-19 days following exposure. Clinical manifestations begin acutely with malaise, fever, rigors, vomiting, headache, and backache; 15% of patients developed delirium. Approximately 10% of light-skinned patients exhibited an erythematous rash during this phase. Two to three days later, an enanthem appears concomitantly with a discrete rash about the face, hands and forearms. Following eruptions on the lower extremities, the rash spread centrally to the trunk over the next week. Lesions quickly progressed from macules to

papules, and eventually to pustular vesicles. Lesions were more abundant on the extremities and face, and this centrifugal distribution is an important diagnostic feature. In distinct contrast to varicella, lesions on various segments of the body remain generally synchronous in their stages of development. From 8 to 14 days after onset, the pustules form scabs that leave depressed depigmented scars upon healing. Although variola concentrations in the throat, conjunctiva, and urine diminish with time, virus can be readily recovered from scabs throughout convalescence. Therefore, patients should be isolated and considered infectious until all scabs separate. For the past century, two distinct types of smallpox were recognized. Variola minor was distinguished by milder systemic toxicity and more diminutive pox lesions, and caused 1% mortality in unvaccinated victims. However, the prototypical disease variola major caused mortality of 3% and 30% in the vaccinated and unvaccinated, respectively. Other clinical forms associated with variola major, flat-type and hemorrhagic type smallpox were notable for severe mortality. A naturally occurring relative of variola, monkey pox, occurs in Africa, and is clinically indistinguishable from smallpox with the exception of a lower case fatality rate and notable enlargement of cervical and inguinal lymph nodes.

h. **Venezuelan Equine Encephalitis:** Incubation period 1-6 days. Acute systemic febrile illness with encephalitis developing in a small percentage (4% children; < 1% adults). Generalized malaise, spiking fevers, rigors, severe headache, photophobia, and myalgias for 24-72 hours. Nausea, vomiting, cough, sore throat, and diarrhea may follow. Full recovery from malaise and fatigue takes 1-2 weeks. The incidence of CNS disease and associated morbidity and mortality would be much higher after a BW attack. Susceptibility is high (90-100%), and nearly 100% of those infected develop overt illnesses. The overall case fatality rate for VEE is < 1%, although it is somewhat higher in the very young or aged. Recovery from an infection results in excellent short-term and long-term immunity. VEE is primarily an acute, incapacitating, febrile illness with encephalitis developing in only a small percentage of the infected population. Most VEE infections are mild (EEE and WEE are predominantly encephalitis infections). After an incubation period from 1-6 days, onset is usually sudden. The acute phase lasts 24-72 hours and is manifested by generalized malaise, chills, spiking high fevers (38˚ C-40.5 ˚ C), rigors, severe headache, photophobia, and myalgias in the legs and lumbosacral area. Nausea, vomiting, cough, sore throat, and diarrhea may follow. Physical signs include conjunctival injection, erythematous pharynx and muscle tenderness. Patients would be incapacitated by malaise and fatigue for 1-2 weeks before full recovery. During natural epidemics, approximately 4% of infected children (<15 years old) and less than 1% of adults will develop signs of severe CNS infection (35% fatality for children and 10% for adults). Adults rarely develop neurologic complications during natural infections. Experimental aerosol challenges

in animals suggest that the incidence of CNS disease and associated morbidity and mortality would be much higher after a BW attack, as the VEE virus would infect the olfactory nerve and spread directly to the CNS. Mild CNS findings would include lethargy, somnolence, or mild confusion, with or without nuchal rigidity. Seizures, ataxia, paralysis, or coma follow more severe CNS involvement. VEE infection during pregnancy may cause encephalitis in the fetus, placental damage, abortion, or severe congenital neuroanatomical anomalies.

i. **Viral Hemorrhagic Fevers (VHF):** VHFs are febrile illnesses which can feature flushing of the face and chest, petechiae, bleeding, edema, hypotension, and shock. Malaise, myalgias, headache, vomiting, and diarrhea may occur in any of the hemorrhagic fevers. The clinical syndrome that these viruses may cause is generally referred to as viral hemorrhagic fever, or VHF. The target organ in the VHF syndrome is the vascular bed; accordingly, the dominant clinical features are usually due to microvascular damage and changes in vascular permeability. Not all infected patients develop VHF. There is both divergence and uncertainty about which host factors and viral strain characteristics might be responsible for the mechanisms of disease. For example, an immunopathogenic mechanism has been identified for dengue hemorrhagic fever, which usually occurs among patients previously infected with a heterologous dengue serotype. Antibody directed against the previous strain enhances uptake of dengue virus by circulating monocytes. These cells express viral antigens on their surfaces. Lysis of the infected monocytes by cytotoxic T-cell responses results in the release of pro-inflammatory cytokines, pro-coagulants, and anticoagulants, which in turn results in vascular injury and permeability, complement activation, and a systemic coagulopathy. DIC has been implicated in Rift Valley, Marburg and Ebola fevers, but in most VHFs the etiology of the coagulopathy is multifactorial (e.g., hepatic damage, consumptive coagulopathy, and primary marrow injury to megakaryocytes). Common symptoms are fever, myalgia, and prostration. Physical examination may reveal only conjunctival injection, mild hypotension, flushing, and petechial hemorrhages. Full-blown VHF typically evolves to shock and generalized mucous membrane hemorrhage, and often is accompanied by evidence of pulmonary hematopoietic, and neurologic involvement. Renal insufficiency is proportional to cardiovascular compromise, except in HFRS, which features renal failure as an integral part of the disease process. Apart from epidemiologic and intelligence information, some distinctive clinical features may suggest a specific etiologic agent. While hepatic involvement is common among the VHFs, a clinical picture dominated by jaundice and other features of hepatitis is only seen in some cases of Rift Valley fever, Congo-Crimean, Marburg, and Ebola HFs, and yellow fever. Kyanasur Forest disease and Omsk hemorrhagic fever are notable for pulmonary involvement, and a biphasic illness with subsequent CNS manifestations. Among the arenavirus infections, Lassa fever can

cause severe peripheral edema due to capillary leak, but hemorrhage is uncommon, while hemorrhage is commonly caused by the South American arenaviruses. Severe hemorrhage and nosocomial transmission are typical for Congo-Crimean HF. Retinitis is commonly seen in Rift Valley fever, and hearing loss is common among Lassa fever survivors. Because of their worldwide occurrence, additional consideration should be given to Hantavirus infections. Classic HFRS has a severe course that progresses sequentially from fever through hemorrhage, shock, renal failure, and polyuria. Nephropathia endemica features prominent fever, myalgia, abdominal pain, and oliguria, without shock or severe hemorrhagic manifestations. North American cases of Hantavirus Pulmonary Syndrome (HPS) due to the Sin Nombre virus lack hemorrhagic manifestations and renal failure, but nevertheless carry a very high mortality due to rapidly progressive and severe pulmonary capillary leak, which presents as ARDS. These syndromes may overlap. Subclinical or clinical pulmonary edema may occur in HFRS and nephropathia endemica, while HFRS has complicated HPS due to South American Hantaviruses and the Bayou and Black Creek Canal viruses in North America. Mortality may be substantial, ranging from 0.2% percent for nephropathia endemica, to 50 to 90 percent among Ebola victims.

j. **Botulinum:** Usually begins with cranial nerve palsies, including ptosis, blurred vision, diplopia, dry mouth and throat, dysphagia, and dysphonia. This is followed by symmetrical descending flaccid paralysis, with generalized weakness and progression to respiratory failure. Symptoms begin as early as 12-36 hours after inhalation, but may take several days after exposure to low doses of toxin. The onset of symptoms of inhalation botulism usually occurs from 12 to 36 hours following exposure, but can vary according to the amount of toxin absorbed, and could be reduced following a BW attack. Recent primate studies indicate that the signs and symptoms may not appear for several days when a low dose of the toxin is inhaled versus a shorter time period following ingestion of toxin or inhalation of higher doses. Cranial nerve palsies are prominent early, with eye symptoms such as blurred vision due to mydriasis, diplopia, ptosis, and photophobia, in addition to other cranial nerve signs such as dysarthria, dysphonia, and dysphagia. Flaccid skeletal muscle paralysis follows, in a symmetrical, descending, and progressive manner. Collapse of the upper airway may occur due to weakness of the oropharyngeal musculature. As the descending motor weakness involves the diaphragm and accessory muscles of respiration, respiratory failure may occur abruptly. Progression from onset of symptoms to respiratory failure has occurred in as little as 24 hours in cases of severe food borne botulism. The autonomic effects of botulism are manifested by typical anticholinergic signs and symptoms: dry mouth, ileus, constipation, and urinary retention. Nausea and vomiting may occur as nonspecific sequelae of an ileus. Dilated pupils (mydriasis) are seen in approximately 50 percent of cases. Sensory symptoms usually do not occur. Botulinum

toxins do not cross the blood/brain barrier and do not cause CNS disease. However, the psychological sequelae of botulism may be severe and require specific intervention. Physical examination usually reveals an afebrile, alert, and oriented patient. Postural hypotension may be present. Mucous membranes may be dry and crusted and the patient may complain of dry mouth or sore throat. There may be difficulty with speaking and swallowing. Gag reflex may be absent. Pupils may be dilated and even fixed. Ptosis and extraocular muscle palsies may also be present. Variable degrees of skeletal muscle weakness may be observed depending on the degree of progression in an individual patient. Deep tendon reflexes may be present or absent. With severe respiratory muscle paralysis, the patient may become cyanotic or exhibit narcosis from CO 2 retention.

k. **Ricin:** Acute onset of fever, chest tightness, cough, dyspnea, nausea, and arthralgias occurs 4 to 8 hours after inhalational exposure. Airway necrosis and pulmonary capillary leak resulting in pulmonary edema would likely occur within 18-24 hours, followed by severe respiratory distress and death from hypoxemia in 36-72 hours. The clinical picture in intoxicated victims would depend on the route of exposure. After aerosol exposure, signs and symptoms would depend on the dose inhaled. Accidental sublethal aerosol exposures which occurred in humans in the 1940's were characterized by acute onset of the following symptoms in 4 to 8 hours: fever, chest tightness, cough, dyspnea, nausea, and arthralgias. The onset of profuse sweating some hours later was commonly the sign of termination of most of the symptoms. Although lethal human aerosol exposures have not been described, the severe pathophysiologic changes seen in the animal respiratory tract, including necrosis and severe alveolar flooding, are probably sufficient to cause death from ARDS and respiratory failure. Time to death in experimental animals is dose dependent, occurring 36-72 hours post inhalation exposure. Humans would be expected to develop severe lung inflammation with progressive cough, dyspnea, cyanosis and pulmonary edema. By other routes of exposure, ricin is not a direct lung irritant; however, intravascular injection can cause minimal pulmonary perivascular edema due to vascular endothelial injury. Ingestion causes necrosis of the gastrointestinal epithelium, local hemorrhage, and hepatic, splenic, and renal necrosis. Intramuscular injection causes severe local necrosis of muscle and regional lymph nodes with moderate visceral organ involvement.

l. **Staphylococcal Enterotoxin B:** Latent period of 3-12 hours after aerosol exposure is followed by sudden onset of fever, chills, headache, myalgia, and nonproductive cough. Some patients may develop shortness of breath and retrosternal chest pain. Patients tend to plateau rapidly to a fairly stable clinical state. Fever may last 2 to 5 days, and cough may persist for up to 4 weeks. Patients may also present with nausea, vomiting, and diarrhea if they swallow the toxin. Presumably, higher exposure can lead to septic shock and death. Symptoms of SEB intoxication begin after a latent period of 3-12 hours after inhalation, or 4-10 hours after ingestion.

Symptoms include nonspecific flu-like symptoms (fever, chills, headache, myalgias), and specific features dependent on the route of exposure. Oral exposure results in predominantly gastrointestinal symptoms: nausea, vomiting, and diarrhea. Inhalation exposures produce predominantly respiratory symptoms: nonproductive cough, retrosternal chest pain, and dyspnea. GI symptoms may accompany respiratory exposure due to inadvertent swallowing of the toxin after normal mucocilliary clearance. Respiratory pathology is due to the activation of pro-inflammatory cytokine cascades in the lungs, leading to pulmonary capillary leak and pulmonary edema. Severe cases may result in acute pulmonary edema and respiratory failure. The fever may last up to five days and range from 103 to 106 degrees F, with variable degrees of chills and prostration. The cough may persist up to four weeks, and patients may not be able to return to duty for two weeks. Physical examination in patients with SEB intoxication is often unremarkable. Conjunctival injection may be present, and postural hypotension may develop due to fluid losses. Chest examination is unremarkable except in the unusual case where pulmonary edema develops. The chest X-ray is also generally normal, but in severe cases increased interstitial markings, atelectasis, and possibly overt pulmonary edema or an ARDS picture may develop.

m. **T-2 Mycotoxin**: Exposure causes skin pain, pruritus, redness, vesicles, necrosis and sloughing of the epidermis. Effects on the airway include nose and throat pain, nasal discharge, itching and sneezing, cough, dyspnea, wheezing, chest pain and hemoptysis. Toxin also produces effects after ingestion or eye contact. Severe intoxication results in prostration, weakness, ataxia, collapse, shock, and death. In a BW attack with trichothecenes, the toxin(s) can adhere to and penetrate the skin, be inhaled, and can be ingested. In the alleged yellow rain incidents, symptoms of exposure from all 3 routes coexisted. Contaminated clothing can serve as a reservoir for further toxin exposure. Early symptoms beginning within minutes of exposure include burning skin pain, redness, tenderness, blistering, and progression to skin necrosis with leathery blackening and sloughing of large areas of skin. Upper respiratory exposure may result in nasal itching, pain, sneezing, epistaxis, and rhinorrhea. Pulmonary/tracheobronchial toxicity produces dyspnea, wheezing, and cough. Mouth and throat exposure causes pain and blood tinged saliva and sputum. Anorexia, nausea, vomiting and watery or bloody diarrhea with crampy abdominal pain occurs with gastrointestinal toxicity. Eye pain, tearing, redness, foreign body sensation and blurred vision may follow ocular exposure. Skin symptoms occur in minutes to hours and eye symptoms in minutes. Systemic toxicity can occur via any route of exposure, and results in weakness, prostration, dizziness, ataxia, and loss of coordination. Tachycardia, hypothermia, and hypotension follow in fatal cases. Death may occur in minutes, hours or days. The most common symptoms are vomiting, diarrhea, skin involvement with burning pain, redness and pruritus, rash or blisters, bleeding, and dyspnea. A late

effect of systemic absorption is pancytopenia, predisposing to bleeding and sepsis.

BWP-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments

STANDARDS:

1. Discuss the importance of follow-up care
2. Discuss procedure for obtaining follow-up appointments
3. Emphasize importance of keeping appointments and following the recommendations established by the city, county, state, and federal health care organizations.
4. Encourage the patient to seek further management if:
   a. Significant worsening of symptoms occurs
   b. Symptoms last longer than expected

BWP-I INFORMATION

OUTCOME: The patient/family will receive information about biological weapons as appropriate

STANDARDS:

1. Identify the suspected biological weapon that the patient/family has been exposed to or that the patient/family is interested in learning about.

   a. **Anthrax:** Bacillus anthracis, the causative agent of Anthrax, is a gram-positive, sporulating rod. The spores are the usual infective form. Anthrax is primarily a zoonotic disease of herbivores, with cattle, sheep, goats, and horses being the usual domesticated animal hosts, but other animals may be infected. Humans generally contract the disease when handling contaminated hair, wool, hides, flesh, blood and excreta of infected animals and from manufactured products such as bone meal. Infection is introduced through scratches or abrasions of the skin, wounds, inhalation of spores, eating insufficiently cooked infected meat, or by biting flies. The primary concern for intentional infection by this organism is through inhalation after aerosol dissemination of spores. All human populations are susceptible. The spores are very stable and may remain viable for many years in soil and water. They resist sunlight for varying periods.

   b. **Brucellosis:** Brucellosis is one of the world's most important veterinary diseases, and is caused by infection with one of six species of Brucellae, a group of gram-negative cocco-baccillary facultative intracellular pathogens. In animals, brucellosis primarily involves the reproductive tract, causing septic abortion and orchitis, which, in turn, can result in sterility. Consequently, brucellosis is a disease of great potential economic impact in the animal husbandry industry. Four species (B. abortus, B. melitensis, B. suis, and, rarely, B. canis) are pathogenic in humans. Infections in abattoir and laboratory workers suggest that the Brucellae are highly infectious via the aerosol route. It is estimated that inhalation of only 10 to 100 bacteria is sufficient to cause disease in man

   c. **Glanders and Melioidosis:** The causative agents of Glanders and Melioidosis are Burkholderia mallei and Burkholderia pseudomallei, respectively. Both are gram-negative bacilli with a "safety-pin" appearance on microscopic examination. Both pathogens affect domestic and wild animals, which, like humans, acquire the diseases from inhalation or contaminated injuries. B. mallei is primarily noted for producing disease in horses, mules, and donkeys. In the past man has seldom been infected, despite frequent and often close contact with infected animals. This may be the result of exposure to low concentrations of organisms from infected sites in ill animals and because strains virulent for equids are often less virulent for man. There are four basic forms of disease in horses and man. The acute forms are more common in mules and donkeys, with death typically occurring 3 to 4 weeks after illness

onset. The chronic form of the disease is more common in horses and causes generalized lymphadenopathy, multiple skin nodules that ulcerate and drain, and induration, enlargement, and nodularity of regional lymphatics on the extremities and in other areas. The lymphatic thickening and induration has been called farcy. Human cases have occurred primarily in veterinarians, horse and donkey caretakers, and abattoir workers. B. pseudomallei is widely distributed in many tropical and subtropical regions. The disease is endemic in Southeast Asia and northern Australia. In northeastern Thailand, B. pseudomallei, is one of the most common causative agents of community-acquired septicemia. Melioidosis presents in humans in several distinct forms, ranging from a subclinical illness to an overwhelming septicemia, with a 90% mortality rate and death within 24-48 hours after onset. Also, melioidosis can reactivate years after primary infection and result in chronic and life-threatening disease. These organisms spread to man by invading the nasal, oral, and conjunctival mucous membranes, by inhalation into the lungs, and by invading abraded or lacerated skin. Aerosols from cultures have been observed to be highly infectious to laboratory workers. Biosafety level 3 containment practices are required when working with these organisms in the laboratory. Since aerosol spread is efficient, and there is no available vaccine or reliable therapy, B. mallei and B. pseudomallei have both been viewed as potential BW agents.

d. **Plague:** Yersinia pestis is a rod-shaped, non-motile, non-sporulating, gram-negative bacterium of the family Enterobacteraceae. It causes plague, a zoonotic disease of rodents (e.g., rats, mice, ground squirrels). Fleas that live on the rodents can transmit the bacteria to humans, who then suffer from the bubonic form of plague. The bubonic form may progress to the septicemic and/or pneumonic forms. Pneumonic plague would be the predominant form after a purposeful aerosol dissemination. All human populations are susceptible. Recovery from the disease is followed by temporary immunity. The organism remains viable in water, moist soil, and grains for several weeks. At near freezing temperatures, it will remain alive from months to years but is killed by 15 minutes of exposure to 55°C. It also remains viable for some time in dry sputum, flea feces, and buried bodies but is killed within several hours of exposure to sunlight.

e. **Q-Fever:** The endemic form of Q fever is a zoonotic disease caused by the rickettsia, Coxiella burnetii. Its natural reservoirs are sheep, cattle, goats, dogs, cats and birds. The organism grows to especially high concentrations in placental tissues. The infected animals do not develop the disease, but do shed large numbers of the organisms in placental tissues and body fluids including milk, urine, and feces. Exposure to infected animals at parturition is an important risk factor for endemic disease. Humans acquire the disease by inhalation of aerosols contaminated with the organisms. Farmers and abattoir workers are at greatest risk occupationally. A biological warfare attack with Q fever

would cause a disease similar to that occurring naturally. Q fever is also a significant hazard in laboratory personnel who are working with the organism.

f. **Tularemia:** Francisella tularensis, the causative agent of tularemia, is a small, aerobic non-motile, gram-negative cocco-bacillus. Tularemia (also known as rabbit fever and deer fly fever) is a zoonotic disease that humans typically acquire after skin or mucous membrane contact with tissues or body fluids of infected animals, or from bites of infected ticks, deerflies, or mosquitoes. Less commonly, inhalation of contaminated dusts or ingestion of contaminated foods or water may produce clinical disease. Respiratory exposure by aerosol would typically cause typhoidal or pneumonic tularemia. F. tularensis can remain viable for weeks in water, soil, carcasses, hides, and for years in frozen rabbit meat. It is resistant for months to temperatures of freezing and below. It is easily killed by heat and disinfectants.

g. **Smallpox:** Smallpox is caused by the Orthopox virus, variola, which occurs in at least two strains, variola major and the milder disease, variola minor. Despite the global eradication of smallpox and continued availability of a vaccine, the potential weaponization of variola continues to pose a military threat. This threat can be attributed to the aerosol infectivity of the virus, the relative ease of large-scale production, and an increasingly Orthopoxvirus-naive populace. Although the fully developed cutaneous eruption of smallpox is unique, earlier stages of the rash could be mistaken for varicella. Secondary spread of infection constitutes a nosocomial hazard from the time of onset of a smallpox patient's exanthem until scabs have separated. Quarantine with respiratory isolation should be applied to secondary contacts for 17 days post-exposure. Vaccinia vaccination and vaccinia immune globulin each possess some efficacy in post-exposure prophylaxis.

h. **Venezuelan Equine Encephalitis:** The Venezuelan equine encephalitis (VEE) virus complex is a group of eight mosquito-borne alphaviruses that are endemic in northern South America and Trinidad and causes rare cases of human encephalitis in Central America, Mexico, and Florida. These viruses can cause severe diseases in humans and Equidae (horses, mules, burros and donkeys). Natural infections are acquired by the bites of a wide variety of mosquitoes. Equidae serve as amplifying hosts and source of mosquito infection. Western and Eastern Equine Encephalitis viruses are similar to the VEE complex, are often difficult to distinguish clinically, and share similar aspects of transmission and epidemiology. The human infective dose for VEE is considered to be 10-100 organisms, which is one of the principal reasons that VEE is considered a militarily effective BW agent. Neither the population density of infected mosquitoes nor the aerosol concentration of virus particles has to be great to allow significant transmission of VEE in a BW attack. There is no evidence of direct human-to-human or horse-to-human transmission. Natural aerosol

transmission is not known to occur. VEE particles are not considered stable in the environment, and are thus not as persistent as the bacteria responsible for Q fever, tularemia or anthrax. Heat and standard disinfectants can easily kill the VEE virus complex.

i. **Viral Hemorrhagic Fevers (VHF):** The viral hemorrhagic fevers are a diverse group of illnesses caused by RNA viruses from four viral families. The Arenaviridae include the etiologic agents of Argentine, Bolivian, and Venezuelan hemorrhagic fevers, and Lassa fever. The Bunyaviridae include the members of the Hantavirus genus, the Congo-Crimean hemorrhagic fever virus from the Nairovirus genus, and the Rift Valley fever virus from the Phlebovirus genus; the Filoviridae include Ebola and Marburg viruses; and the Flaviviridae include dengue and yellow fever viruses. These viruses are spread in a variety of ways; some may be transmitted to humans through a respiratory portal of entry. Although evidence for weaponization does not exist for many of these viruses, they are included in this handbook because of their potential for aerosol dissemination or weaponization, or likelihood for confusion with similar agents that might be weaponized.

j. **Botulinum:** The botulinum toxins are a group of seven related neurotoxins produced by the spore-forming bacillus Clostridium botulinum and two other Clostridia species. These toxins, types A through G, are the most potent neurotoxins known; paradoxically, they have been used therapeutically to treat spastic conditions (strabismus, blepharospasm, torticollis, tetanus) and cosmetically to treat wrinkles. The spores are ubiquitous; they germinate into vegetative bacteria that produce toxins during anaerobic incubation. Industrial-scale fermentation can produce large quantities of toxin for use as a BW agent. There are three epidemiologic forms of naturally occurring botulism¾food borne, infantile, and wound. Botulinum could be delivered by aerosol or used to contaminate food or water supplies. When inhaled, these toxins produce a clinical picture very similar to food borne intoxication, although the time to onset of paralytic symptoms after inhalation may actually be longer than for food borne cases, and may vary by type anddose of toxin. The clinical syndrome produced by these toxins is known as "botulism".

k. **Ricin:** Ricin is a potent protein cytotoxin derived from the beans of the castor plant (Ricinus communis). Castor beans are ubiquitous worldwide, and the toxin is fairly easy to extract; Therefore, ricin is potentially widely available. When inhaled as a small particle aerosol, this toxin may produce pathologic changes within 8 hours and severe respiratory symptoms followed by acute hypoxic respiratory failure in 36-72 hours. When ingested, ricin causes severe gastrointestinal symptoms followed by vascular collapse and death. This toxin may also cause disseminated intravascular coagulation, microcirculatory failure and multiple organ failure if given intravenously in laboratory animals.

l. **Staphylococcal Enterotoxin B:** Staphylococcus aureus produces a number of exotoxins, one of which is Staphylococcal enterotoxin B, or SEB. Such toxins are referred to as exotoxins since they are excreted from the organism, and since they normally exert their effects on the intestines they are called enterotoxins. SEB is one of the pyrogenic toxins that commonly causes food poisoning in humans after the toxin is produced in improperly handled foodstuffs and subsequently ingested. SEB has a very broad spectrum of biological activity. This toxin causes a markedly different clinical syndrome when inhaled than it characteristically produces when ingested. Significant morbidity is produced in individuals who are exposed to SEB by either portal of entry to the body.

2. **T-2 Mycotoxins:** The trichothecene (T-2) mycotoxins are a group of over 40 compounds produced by fungi of the genus Fusarium, a common grain mold. They are small molecular weight compounds, and are extremely stable in the environment. They are the only class of toxin that is dermally active, causing blisters within a relatively short time after exposure (minutes to hours). Dermal, ocular, respiratory, and gastrointestinal exposures would be expected after an attack with mycotoxins.

BWP-L LITERATURE

OUTCOME: The patient/family will receive written information about exposure to biological weapons

STANDARDS:

1. Provide the patient/family with written patient information literature on biological weapons.
   a. Discuss the content of the patient information literature with the patient/family.

BWP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will strive to make lifestyle adaptations necessary to limit exposure, prevent complications and prevent the spread of exposure to biological weapons as appropriate.

STANDARDS:

1. Review lifestyle aspects/changes that the patient has control over – diet, exercise, safety, injury prevention, avoidance of high-risk behaviors, and fully participating in a treatment plan.
2. Emphasize that an important component in the prevention or treatment of exposure to biological weapons is the patient's adaptation to a healthier, lower risk lifestyle.
3. Emphasize that an important component in the preventing the spread of exposure to biological weapons is the patient's adaptation to a healthier, lower risk lifestyle as appropriate.
4. Emphasize that if patient/family believes that there has been exposure with a biological weapon they should contact a health care professional for advice Usually the patient should remain where they are and fully participate with recommendations in order to limit the possibility of spreading the disease as appropriate.
5. Review the community resources available to assist the patient in making lifestyle changes. Refer as appropriate.

BWP-M MEDICATIONS

OUTCOME: The patient/family will understand the role of medications in the acute treatment of exposure, prophylaxis, and the prevention of disease resulting from exposure to biological weapons as appropriate.

STANDARDS:

1. Discuss the proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
2. Review common side effects, signs of toxicity, and drug interactions of the medications
3. Emphasize the importance of fully participating in the medication plan and explain how effective use of medications may reduce symptoms, complications, and prevent death.

BWP-P PREVENTION

OUTCOME: The patient/family will understand actions that may be taken to prevent exposure to and infection with biological warfare agents

STANDARDS:

1. Instruct patient to avoid contact with people who are suspected of exposure to biological weapons.
2. Instruct patient on the importance of hand washing and maintaining appropriate hygiene.
3. Encourage patient to maintain natural resistance to infection through adequate nutrition, rest, and exercise
4. Encourage patient to receive recommended medications and/or vaccinations for post-exposure prophylaxis and/or threat of biological agents as appropriate.
    a. **Anthrax:** Oral antibiotics for known or imminent exposure. An FDA-licensed vaccine is available. Vaccine schedule is 0.5 ml SC at 0, 2, 4 weeks, then 6, 12, and 18 months (primary series), followed by annual boosters.
    b. **Brucellosis:** There is no human vaccine available against brucellosis, although animal vaccines exist. Chemoprophylaxis is not recommended after possible exposure to endemic disease. Treatment should be considered for high-risk exposure to the veterinary vaccine, inadvertent laboratory exposure, or confirmed biological warfare exposure.
    c. **Glanders and Melioidosis:** Currently, no pre-exposure or post-exposure prophylaxis is available.
    d. **Plague:** For asymptomatic persons exposed to a plague aerosol or to a patient with suspected pneumonic plague, appropriate course of antibiotic therapy or the duration of risk of exposure plus one week. No vaccine is currently available for plague prophylaxis. The previously available licensed, killed vaccine was effective against bubonic plague, but not against aerosol exposure.
    e. **Q-Fever:** Chemoprophylaxis begun too early during the incubation period may delay but not prevent the onset of symptoms. Therefore, appropriate antibiotic therapy should be started 8-12 days post exposure and continued for 5 days. Antibiotic therapy has been shown to prevent clinical disease. An inactivated whole cell IND vaccine is effective in eliciting protection against exposure, but severe local reactions to this vaccine may be seen in those who already possess immunity. Therefore, an intradermal skin test is recommended to detect pre-sensitized or immune individuals.
    f. **Tularemia:** A live, attenuated vaccine is available as an investigational new drug. It is administered once by scarification. A two-week course of tetracycline is effective as prophylaxis when given after exposure.

g. **Smallpox:** Immediate vaccination or revaccination should be undertaken for all personnel exposed.

h. **Venezuelan Equine Encephalitis:** A live, attenuated vaccine is available as an investigational new drug. A second, formalin-inactivated, killed vaccine is available for boosting antibody titers in those initially receiving the first vaccine. No post-exposure immunoprophylaxis. In experimental animals, alpha-interferon and the interferon-inducer poly-ICLC have proven highly effective as post-exposure prophylaxis. There are no human clinical data.

i. **Viral Hemorrhagic Fevers:** The only licensed VHF vaccine is yellow fever vaccine. Prophylactic ribavirin may be effective for Lassa fever, Rift Valley fever, CCHF, and possibly HFRS (Available only as IND under protocol).

j. **Botulinum Toxin:** Pentavalent toxoid vaccine (types A, B, C, D, and E) is available as an IND product for those at high risk of exposure.

k. **Ricin:** There is currently no vaccine or prophylactic antitoxin available for human use, although immunization appears promising in animal models. Use of the protective mask is currently the best protection against inhalation.

l. **Staphylococcal Enterotoxin B:** Use of protective mask. There is currently no human vaccine available to prevent SEB intoxication.

m. **T-2 Mycotoxins:** The only defense is to prevent exposure by wearing a protective mask and clothing (or topical skin protectant) during an attack. No specific immunotherapy or chemotherapy is available for use in the field.

BWP-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in bioterrorism.

STANDARDS:

1. Explain realistic information regarding bioterrorism threats in order to decrease the sense of crisis or anxiety that could arise from the threat or potential threat of biological weapons.
2. Discuss that stress from a threatened act of bioterrorism may be as great and as real as stress from an actual act of bioterrorism.
3. Explain that effective stress management may help reduce the anxiety associated with potential bioterrorism threats.
4. Discuss various stress management strategies such as becoming aware of your own reactions to stress, recognizing and accepting your limits, talking with people you trust about your worries or problems, practicing spiritual and cultural activities and forming as well as practicing a plan.
5. Provide referrals as appropriate.

BWP-TE TESTS

OUTCOME: The patient/family will understand the role of testing in appropriate management of exposure to biological weapons.

STANDARDS:

1. Discuss why a microbiology culture may or may not be required to confirm diagnosis of a biological weapon.
2. Explain what test(s) will be ordered. Provide information on the indication, benefits, and risks of the tests.
3. Explain how test results will be used to guide therapy.

BWP-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments available after exposure to a biological weapon.

STANDARDS:

1. Explain that the treatment plan will be made by patient and the health care team after reviewing available options
    a. **Anthrax:** Although effectiveness may be limited after symptoms are present, high dose antibiotic treatment should be undertaken. Supportive therapy may be necessary.
    b. **Brucellosis:** Antibiotic therapy in combination with other medications for six weeks is usually sufficient in most cases. More prolonged regimens may be required for patients with complications of meningoencephalitis, endocarditis, or osteomyelitis.
    c. **Glanders and Melioidosis:** Therapy will vary with the type and severity of the clinical presentation. Patients with localized disease, may be managed with oral antibiotics for a duration of 60-150 days. More severe illness may require parenteral therapy and more prolonged treatment.
    d. **Plague:** Early administration of antibiotics is critical, as pneumonic plague is invariably fatal if antibiotic therapy is delayed more than 1 day after the onset of symptoms.
    e. **Q-Fever:** Q fever is generally a self-limited illness even without treatment, but antibiotic therapy should be provided to prevent complications of the disease. Q fever endocarditis (rare) is much more difficult to treat.
    f. **Tularemia:** Administration of antibiotics with early treatment is very effective.
    g. **Smallpox:** At present there is no effective chemotherapy, and treatment of a clinical case remains supportive.
    h. **Venezuelan Equine Encephalitis:** Treatment is supportive only. Treat uncomplicated VEE infections with analgesics to relieve headache and myalgia. Patients who develop encephalitis may require anticonvulsants and intensive supportive care to maintain fluid and electrolyte balance, ensure adequate ventilation, and avoid complicating secondary bacterial infections.
    i. **Viral Hemorrhagic Fevers:** Intensive supportive care may be required. Antiviral therapy with ribavirin may be useful in several of these infections (Available only as IND under protocol). Convalescent plasma may be effective in Argentine hemorrhagic fever (Available only as IND under protocol).

j. **Botulinum Toxin:** Early administration of trivalent licensed antitoxin or heptavalent antitoxin (IND product) may prevent or decrease progression to respiratory failure and hasten recovery. Intubation and ventilatory assistance for respiratory failure. Tracheostomy may be required.

k. **Ricin:** Management is supportive and should include treatment for pulmonary edema. Gastric lavage and cathartics are indicated for ingestion, but charcoal is of little value for large molecules such as ricin.

l. **Staphylococcal Enterotoxin B:** Treatment is limited to supportive care. Artificial ventilation might be needed for very severe cases, and attention to fluid management is important.

m. **T-2 Mycotoxin:** There is no specific antidote. Treatment is supportive. Soap and water washing, even 4-6 hours after exposure can significantly reduce dermal toxicity; washing within 1 hour may prevent toxicity entirely. Superactivated charcoal should be given orally if the toxin is swallowed.

BL—Blood Transfusions

BL-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications of blood transfusions and the potential complications that might result from withholding blood transfusion.

STANDARDS:

1. Explain that there are two potential major complications from blood transfusions that occasionally occur.
    a. Explain that the patient may develop volume overload as a result of the blood transfusion, particularly if the patient is a neonate, elderly, or has cardiopulmonary disease. The symptoms which should be reported to the nurse immediately may include:
        i. restlessness
        ii. headache
        iii. shortness of breath
        iv. wheezing
        v. cough
        vi. cyanosis
    b. Explain that a transfusion reaction may occur. Explain that transfusion reactions may be severe and can include anaphylaxis or death. Instruct the patient/family that the following symptoms should be reported to the nurse immediately. Discuss that the symptoms are usually mild and may include:
        i. hives
        ii. itching
        iii. rashes
        iv. fever
        v. chills
        vi. muscle aches
        vii. back pain
        viii. chest pain
        ix. headaches
        x. warmth in the vein
2. Explain that blood supplies are currently thoroughly tested for blood borne diseases such as HIV or hepatitis. There still remains a small risk of transmission of blood borne disease from transfusion of blood or blood components.

BL-EQ EQUIPMENT

OUTCOME: The patient/family will have a basic understanding of the use of equipment utilized during blood administration.

STANDARDS:

1. Explain the indications for and benefits of the infusion equipment, if utilized.
2. Explain the use of equipment utilized to monitor the patient during the blood transfusion.
3. Explain the various alarms that may sound and the proper action to take.
4. Emphasize the importance of not tampering with any infusion control device.

BL-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

BL-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about blood transfusions.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding blood transfusions.
2. Discuss the content of the patient information literature with the patient/family.

BL-S SAFETY

OUTCOME: The patient/family will understand the precautions taken to ensure that blood transfusions are safe and provide minimal risk for disease transmission or increased health risk.

STANDARDS:

1. Explain that blood collecting agencies make every effort to assure that the blood collected for donation is safe.
2. Explain that blood donors are carefully screened through a medical and social history before they donate blood.
3. Explain that donated blood is thoroughly tested to make sure it is free from disease or infection.
4. Explain that the laboratory carefully tests donated blood and the patient's blood to make sure that they are compatible.
5. Explain that two nurses will check to verify that the transfusion is intended for the patient and that it has been properly tested for compatibility.
6. Explain that the patient will be closely monitored by the nursing staff during the transfusion so that any complications or reactions will be identified and treated immediately.
7. Explain that it is the responsibility of the patient/family to report any suspected reactions immediately.

BL-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as appropriate, including the risks of refusing to have the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain the meaning of the test results, as appropriate.

BL-TX TREATMENT

OUTCOME: The patient/family will understand the necessity for the blood transfusion.

STANDARDS:

1. Explain that a blood transfusion is the transference of blood from one person to another.
2. Explain that blood transfusions are necessary to treat blood losses related to surgery or trauma, to treat blood disorders, or treat cancer or leukemia. Identify the specific reason that the patient requires a transfusion.
3. Explain that there are a variety of blood components available. Describe the blood component that will be administered and explain the necessity as related to the specific injury or disease process.

BURN—Burns

BURN-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications associated with burns.

STANDARDS:

1. Explain that burned tissue is very susceptible to infections.
2. Review the symptoms of a generalized infection, i.e., high fever, swelling or oozing, spreading redness, red streaking, increased tenderness/pain, changes in mental status, decreased urine output.
3. Review the effects of uncontrolled burn or wound infections (i.e., cellulitis) or generalized infection, i.e., loss of limb, need for facsiotomy and skin grafting, multi-organ failure, death.
4. Explain that scarring and/or tissue discoloration is common after healing of a burn.
5. Emphasize the importance of early treatment to prevent complications.
6. Explain that third degree or large body surface area burns are particularly prone to infection dehydration and other metabolic derangement that can be lethal.

BURN-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

BURN-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology and staging of burns.

STANDARDS:

1. Explain that burns may be the result of various causes such as fire and heat or steam; chemical or electrical burns and sunburns.
2. Explain the first step is to determine the degree and the extent of damage to body tissues:
    a. First-degree burns are those in which only the outer layer of skin (epidermis) is burned. The skin is usually red, with swelling and pain sometimes present. The outer layer of skin hasn't been burned through. Treat a first degree burn as a minor burn unless it involves substantial portions of the hands, feet, face, or other large areas of the body.
    b. Second-degree burns are when the first layer of skin has been burned through and the second layer of skin (dermis) also is burned. Blisters develop and the skin takes on an intensely reddened, splotchy appearance. Second-degree burns produce severe pain and swelling.
    c. Third-degree burns are the most serious and are painless and involve all layers of the skin. Fat, muscle and even bone may be affected. Areas may be charred black or appear dry and white. Difficulty in inhaling and exhaling, carbon monoxide poisoning or other toxic effects may occur if smoke inhalation accompanies the burn.
3. Chemical burns are injuries to the body as a result of chemicals (i.e., cleaning materials, gasoline).
4. Explain that electrical burns are caused by the skin or body coming in contact with electricity and while an electrical burn may appear minor, the damage can extend deep into the tissues beneath the skin. If a strong electrical current passes through the body, internal damage such as heart rhythm disturbance or cardiac arrest can occur. Explain that electrical burns should be evaluated by a healthcare provider.
5. Explain that sunburn is the result of overexposure to the sun's ultraviolet (UV) radiation. Repeated exposure to UV radiation both tans and damages your skin. The signs and symptoms of sunburn usually appear within a few hours of exposure, bringing pain, redness, swelling and occasional blistering. Because sun burn often affects a large area of your skin, sunburn can cause headache, fever, fatigue, and dehydration. **Refer to SUN**.

BURN-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information appropriate to the type and degree of the burn.

STANDARDS:

1. Provide written information about first, second, third-degree burns, chemical or electrical burns or sunburn.
2. Discuss the content of the patient information literature.

BURN-P PREVENTION

OUTCOME: The patient/family will understand the factors associated with an increased risk of burns and how to lower the risk of burns.

STANDARDS:

1. Explain that all homes should have ABC fire extinguishers in several locations throughout the home.
2. Explain the importance of having fire escape ladders in multi-story homes.
3. Discuss safety issues:
   a. To prevent fire burns:
      (1) Install smoke detectors
      (2) Don't smoke in bed
      (3) Practice home fire drills and "stop, drop, and roll"
      (4) Don't let children play with matches, lighters, flames, or fireworks
      (5) Explain that fireworks are extremely dangerous
      (6) Ensure heat lamps and other sources of heat have timers or appropriate safety devices
      (7) Never leave burning candles unattended
      (8) Assure that electrical wiring, outlets, and electrical devices are safe
   b. To prevent chemical burns:
      (1) child-proof cabinets and store chemicals out of the reach of children,
      (2) use caution in storing cleaning materials,
      (3) wear gloves and other protective clothing when using chemicals
   c. To prevent heat/steam burns:
      (1) set your water heater no higher than 120°F
      (2) Test the water temperature before entering or putting children into bathtubs/showers

(3) Use cool water humidifiers not steam vaporizers

(4) Before putting a child into a car seat, touch the seat to check how hot it is. It is a good idea to keep a towel covering the car seat in summer months.

(5) When cooking, turn the handles of pots toward the side or rear of the stove, don't wear loose clothing that can come in contact with the stove. You should always use the back burners first.

(6) Use extreme caution when lifting lids from pots as steam may suddenly be released

(7) Use caution when removing items in a microwave as they may be very hot. Use only microwave approved dishware.

d. To prevent electrical burns:

(1) Put covers on any electrical outlets not currently in use.

(2) Don't use items with frayed or damaged electrical cords.

(3) Don't overload outlets

(4) Keep electrical devices away from water and use ground fault circuit interrupter outlets near water sources

(5) Don't modify electrical cords or plugs

(6) Use power surge protectors

6. Review the dangers inherent in the use of wood-burning stoves, "charcoal pans", kerosene heaters, and other open flames.
7. Encourage the use and proper maintenance of smoke detectors, carbon monoxide detectors, and fire suppression systems.
8. Encourage routine practices of fire escape plans, chimney cleaning, and fireworks safety.
9. Review the safe use of electricity and natural gas.
10. Avoid the use of kerosene or gasoline when burning debris piles.

BURN-TX TREATMENT

OUTCOME: The patient/family will understand the risks and benefits of treatment as well as the possible consequences of not participating with the treatment plan.

STANDARDS:

1. Explain that treatment of burns varies according to the degree, size, and location of the burn. Discuss this individual's specific burn treatment plan.
2. Explain and urge caution:
   a. Don't use butter on a burn as butter may contain salt which can worsen the burn.
   b. Don't use ice, as putting ice on a burn can cause frostbite, further damaging your skin.
   c. Don't break blisters as fluid-filled blisters protect against infection. If blisters break, wash the area with mild soap and water, then apply an antibiotic ointment and a gauze bandage. Clean and change dressings as directed by a healthcare provider. Antibiotic ointments don't make the burn heal faster but they can help prevent infection.
   d. Don't remove any burnt clothing that is "stuck" to the skin as a result of the burn. The victim should be taken immediately to an emergency room. Until arriving at the emergency room, cover the area of the burn with a cool, moist sterile bandage/gauze or clean cloth.
3. **Refer to PM.**

BURN -WC WOUND CARE

OUTCOME: The patient/family will understand the necessity and procedure for proper wound care and infection control measures.

STANDARDS:

1. Explain the reasons to care appropriately for the burn, i.e., decreased infection rate, improved healing.
2. Explain the correct procedure for caring for this patient's burn.
3. Explain signs or symptoms that would prompt immediate follow-up, i.e.; increasing redness, purulent discharge, fever, increasing pain or swelling.
4. Detail the supplies necessary for care of this burn (if any) and how/where they might be obtained and proper methods for disposal of used supplies.
5. As appropriate, have the patient/family demonstrate burn care techniques.
6. Emphasize the importance of follow-up.

C

CVA—Cerebrovascular Disease

CVA-C COMPLICATIONS

OUTCOME: The patient/family will understand how to prevent the complications of cerebrovascular disease.

STANDARDS:

1. Discuss common complications of cerebrovascular disease, i.e., loss of function, loss of speech, confusion, loss of independence.
2. Discuss the importance of following the prescribed treatment plan including physical therapy, medications and rehabilitation in maximizing potential.

CVA-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

CVA-DP DISEASE PROCESS

OUTCOME: The patient will understand cerebrovascular disease and its symptoms.

STANDARDS:

1. Explain that cerebrovascular disease is the result of the buildup of plaque in the interior wall of the arteries of the brain.
2. Review the factors related to the development of cerebrovascular disease - smoking, uncontrolled hypertension, elevated cholesterol, obesity, uncontrolled diabetes, sedentary lifestyle, increasing age, and male sex. Emphasize that a history of coronary artery disease greatly increases the risk of cerebrovascular disease and vice-versa.
3. Review the signs of cerebrovascular disease, i.e., weakness, numbness, confusion, slurred speech, episodes of "blacking out."
4. Explain that the symptoms of cerebrovascular disease occur when the brain is deprived of oxygen.
5. Differentiate between temporary ischemic attack (the temporary loss of oxygen to the brain) and "stroke" (a permanent loss of oxygen to the brain resulting in permanent damage and loss of function).
6. Explain that sometimes only a physician, through test interpretation, may be able to differentiate between TIA and stroke.
7. Emphasize that a TIA is a significant warning sign which may be a precursor to a stroke and permanent loss of function. Any TIA or similar symptoms should prompt immediate medical evaluation.
8. Emphasize that effects of a stroke are often reversible with early intervention and appropriate rehabilitation. Refer as appropriate.

CVA-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate (when appropriate) proper use and care of medical equipment.

STANDARDS:

1. Discuss indications for and benefits of prescribed medical equipment to be used during the hospital stay and/or at home after discharge.
2. Discuss and/or demonstrate proper use and care of medical equipment; participate in return demonstration by patient/family.
3. Emphasize infection control principles and the safe use of equipment.

CVA-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of adhering to a treatment regimen, be able to identify appropriate actions to take for symptoms indicating life-threatening ischemia, and will make a plan to obtain and keep appropriate follow-up appointments.

STANDARDS:

1. Discuss the individual's responsibility in the management of cerebrovascular disease.
2. Review treatment plan with the patient, emphasizing the need for keeping appointments, fully participating with medication therapy, adhering to dietary modifications, and maintaining an appropriate activity/rest balance.
3. Review the symptoms which should be reported, i.e., symptoms more frequent or occurring during rest, symptoms lasting longer.

CVA-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of status post stroke patients and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer falls, fewer emergency room visits, fewer hospitalizations and fewer complications.
3. Explain the use and care of any necessary home medical equipment.

CVA-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the cerebrovascular disease.

STANDARDS:

1. Provide patient/family with written patient information literature about cerebrovascular disease.
2. Discuss the content of patient information literature with the patient/family.

CVA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adaptations necessary to maintain optimal health.

STANDARDS:

1. Emphasize that the most important component in the prevention and treatment of cerebrovascular disease is the patient's adaptation to a healthier, lower risk lifestyle.
2. Discuss lifestyle adaptations that may reduce further risk of TIA and/or stroke and improve the quality of life (cease all use of tobacco products, control hypertension and elevated cholesterol through medications, diet and exercise, lose weight as indicated, control diabetes, and increase activity as prescribed by the physician).

CVA-M MEDICATIONS

OUTCOME: The patient will understand the importance of following a prescribed medication regimen.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medications.
2. Emphasize the importance of maintaining strict participation in the medication regimen.

CVA-N NUTRITION

OUTCOME: The patient/family will understand how to control cerebrovascular disease through weight control and diet modification and develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between diet and cerebrovascular disease, hypertension, elevated cholesterol, and obesity.
3. Provide lists of foods that are to be encouraged and avoided. Refer to dietitian or other local resources as available.
4. Assist in developing an appropriate diet plan to achieve optimal weight and cholesterol control.
5. **Refer to LIP**.

CVA-P PREVENTION

OUTCOME: The patient/family will understand ways to prevent CVA.

STANDARDS:

1. Discuss that prevention of cerebrovascular disease is far better than controlling the disease after it has developed.
2. Explain that consuming a diet low in fat, and controlling weight, lipid levels and blood pressure will help to prevent CVA.
3. Discuss that persons with uncontrolled diabetes and uncontrolled hypertension and uncontrolled dyslipidemia are more likely to develop CVA. Stress the importance of controlling these disease processes. **Refer to DM, HTN, LIP, OBS.**

CVA-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient and/or appropriate family member(s) will understand the importance of injury prevention and implement of safety measures.

STANDARDS:

1. Explain to patient/family members the importance of body mechanics and proper lifting techniques to avoid injury.
2. Assist the family in identifying ways to adapt the home to improve safety and prevent injuries, i.e., remove throw rugs, install bars in tub/shower, secure electrical cords.
3. Stress importance and proper use of mobility devices, i.e., cane, walker, wheel chair.

CVA-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in cerebrovascular disease.

STANDARDS:

1. Explain that uncontrolled stress can contribute to increases in blood pressure, which increases the patient's risk for stroke.
2. Explain that uncontrolled stress can interfere with the treatment of cerebrovascular disease.
3. Explain that effective stress management may help prevent progression of cerebrovascular disease, as well as help improve the patient's health and well-being.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality from cerebrovascular disease.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

CVA-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed, the risk(s)/benefit(s) of the test(s) and the risk(s) of refusal of the test(s).

STANDARDS:

1. Explain the test ordered, i.e., CT, MRI, angiography.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.

CVA-TX TREATMENTS

OUTCOME: The patient/family will understand the possible treatments that may be performed based on the test results.

STANDARDS:

1. List the possible procedures that might be utilized to treat the arterial blockage, i.e., angioplasty, carotid endarterectomy.
2. Briefly explain each of the possible treatments.
3. Explain that the treatment decision will be made by the patient and medical team after reviewing the results of diagnostic tests.

CD—Chemical Dependency

Refer to AOD-Alcohol and Other Drugs.

CWP—Chemical Weapons

CWP-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential consequences of exposure to a chemical weapon.

STANDARDS:

1. Discuss with the patient/family the complications that may occur after exposure to chemical weapons as appropriate.

CWP-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

CWP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the expected course of disease resulting from exposure to the chemical weapon.

STANDARDS:

1. Provide an overview of the suspected chemical weapon. Discuss the time course and clinical features of the suspected chemical weapon as appropriate.

   a. **NERVE AGENTS**

   The extent of the poisoning depends on the amount of chemical to which a person was exposed, how the person was exposed, and the length of the exposure. Exposure to low or medium doses can produce runny/watery eyes, pinpoint pupils, eye pain, blurred vision, drooling, excessive sweating, cough, chest tightness, rapid breathing, diarrhea, increased urination, confusion, drowsiness, weakness, headache, nausea, vomiting, abdominal pain, change in heart rate, change in blood pressure. Exposure to a large dose of nerve agents can cause loss of consciousness, convulsions, paralysis, or respiratory failure with the possibility of leading to death. Mild or moderately exposed individuals usually recover completely, but severely exposed individuals are not likely to survive.

   i. **Tabun:** symptoms can occur within a few seconds if exposed to the vapor form, and a few minutes to up to 18 hours after being exposed to the liquid form.

   ii. **Sarin:** is one of the most volatile nerve agents, and can easily transform from a liquid in to a vapor and spread in to the environment. Even a small drop of Sarin can cause sweating and muscle twitching where it touches the skin.

   iii. **Soman:** exposure can occur through skin contact, eye contact, or inhalation. It mixes easily with water and can be used to poison water, or it can also be used to poison with. Victim's clothes can release Soman for up to 30 minutes following exposure, rendering them toxic and likely to infect others. Repeated exposure can lead to accumulation of the chemical in the body due to its slow elimination. Soman vapor is thicker than air, and thus usually settles closer to the ground.

   iv. **VX:** Symptoms can be expected from 4 to 14 hours following exposure to VX. Of all the nerve agents, VX is the most volatile and can be easily transformed into gas. It is also the most toxic and more likely to produce the lethal side effects following exposure.

   b. **BLISTER/VESICANT AGENTS**

   The most likely routes of exposure to blister/vesicant agents are inhalation, dermal contact, and ocular contact. The severity of symptoms

will be dependant upon the amount and route of exposure, as well as the pre-morbid condition of the victim.

i. **Lewisite:** Exposure can occur by skin or eye contact, or breathing in contaminated air. Pain and irritation can occur within seconds, redness within 15 to 30 minutes, followed by blister formation up to several hours later. The blister will eventually become large enough to cover the initial red area. The lesions produced by exposure to Lewisite heal faster, and leave less discoloration. The eyes may become irritated, painful, and swollen with the likelihood of tearing. Patients may also experience runny nose, sneezing, hoarseness, bloody nose, sinus pain, shortness of breath, and cough. Nausea, Vomiting, and diarrhea could be expected, as well as low blood pressure ("Lewisite shock").

ii. **Sulfur Mustard:** sulfur mustard can be carried through the wind over great distances, and can also contaminate water. Exposure to sulfur mustard is usually not fatal. Depending upon the severity of the exposure. The victim may not experience symptoms for up to 2 to 24 hours. Sulfur can cause redness and itching of the skin within 2 to 48 hours of exposure, which may eventually lead to yellow blistering of the skin. The eyes may become irritated, painful, swollen and tearful within the first 3 to 12 hours of a mild to moderate exposure. A severe exposure could result in symptoms occurring within 1 to 2 hours of exposure, and could include light sensitivity, severe pain, or blindness that could be present for up to 10 days following the initiation of symptoms. Runny nose, sneezing, hoarseness, bloody nose, sinus pain, shortness of breath, and cough within 12 to 24 hours of a mild exposure and within 2 to 4 hours of severe exposure can occur. Abdominal pain, diarrhea, fever, nausea, and vomiting may be present. Exposure to the liquid form is more likely to result in second and third degree burns and scarring than is exposure to the vapor form of Sulfur mustard. Excessive inhalation of the vapor can lead to long-term respiratory disorders, repeated respiratory infections, or even death. Lengthy exposure to the eye can cause permanent blindness. Exposure to Sulfur mustard places an individual at higher risk for respiratory and lung cancer.

iii. **Nitrogen Mustards:** These can be found in a variety of forms; oily liquids, vapor, or solid, and with a variety of different smells. The symptoms of Nitrogen exposure usually do not occur immediately, and can take up to several hours to manifest themselves. Skin can become reddened within a few hours, and could be followed by blistering within 6 to 12 hours. The eyes may become irritated, painful, swollen, and tearful, with high amounts of exposure causing blindness. Nose and sinus pain, coughing, sore throat, and shortness of breath may occur within hours. Abdominal pain, nausea, vomiting, diarrhea. Under extreme circumstances, individuals could experience tremors, in coordination, and seizures. The liquid form is more likely to produce second or third degree burns that are more likely to leave scarring later. Excess inhalation of the

vapors can cause long-term respiratory disorders, and excess exposure to the eyes can cause chronic eye problems. Exposure has been associated with bone marrow suppression beginning as early as 3 to 5 days following the exposure, which can lead to anemia, bleeding, and increased risk for infection. Prolonged exposure to nitrogen mustards has been linked top leukemia.

iv. **Phosgene Oxime:** This can cause instant, excruciating pain of the skin almost immediately upon exposure to the chemical. Within seconds, blanching of the skin surrounded by red rings can occur, and within 15 minutes, the skin develops hives. 24 hours later, the whitened areas of the skin become brown and die, leaving a scab. As the skin heals, the patient may continue to experience itching and pain. Immediately following inhalation, victims should expect runny nose, hoarseness, and sinus pain. Absorbing Phosgene through the skin, or inhaling it can cause pulmonary edema (fluid accumulation in the lungs) with symptoms of shortness of breath and cough.

c. **BLOOD AGENTS**

i. **Cyanide**: Toxicity from this agent can be achieved through inhalation, contact with poisoned soil, drinking contaminated water, or eating contaminated food. The extent of the poisoning depends upon the route and length of exposure. The most harmful method of toxicity is through inhalation. As the gaseous form evaporates rather quickly, Cyanide is less toxic in large outdoor areas being that it is less dense than air and rises fast. This agent prevents the adequate delivery of oxygen to cells, and can be detrimental to the heart and brain. Upon exposure, the following symptoms can be seen within minutes; rapid breathing, restlessness, dizziness, weakness, rapid heart rate, headache, nausea, and vomiting. As poisoning progresses, respirations become slow and gasping and the skin may appear slightly blue in color. The lungs may become filled with fluid. Central nervous system symptoms usually occur rapidly, and include excitement, dizziness, nausea, vomiting, headache, and weakness. As poisoning progresses, drowsiness, spasms, lockjaw, convulsions, hallucinations, loss of consciousness, and coma may occur. Exposure to larger amounts may cause convulsions, low blood pressure, slow heart rate, loss of consciousness, respiratory failure leading to death. Survivors of serious Cyanide poisoning may develop heart and brain damage. Personality changes, memory deficits, disturbances in voluntary muscle movements, and the appearance in involuntary muscle movements have also been reported in survivors of Cyanide poisoning. Chronically exposed workers may complain of headache, eye irritation, easy fatigue, chest discomfort, palpitations, loss of appetite, and nosebleeds.

d. **PULMONARY AGENTS**

i. **Chlorine:** This can be found in industry and in households in the form of bleach, pesticides, rubber, and solvents. The gaseous form can be

recognized by its pungent, irritating odor, and it's yellow-green color. Chlorine can manifest its poison effects through skin/eye contact, inhalation, and ingestion of contaminated food or water. The seriousness of the side effects depend on the amount and type of Chlorine exposure. During, or immediately after inhalation of low concentrations victims may experience eye and nasal irritation, sore throat, and coughing. Higher concentration can rapidly lead to respiratory distress with airway constriction, and accumulation of fluid in the lungs. Chlorine can initially increase heart rate and blood pressure, and eventually lead to Cardiovascular collapse due to lack of oxygen. Low exposure the skin can cause burning pain, inflammation, and blisters, while it can cause involuntary blinking, redness, and tearing in the eyes. Following an isolated exposure, lung function can return to near normal in 7-14 days. Though complete recovery usually occurs, a chemical irritant-induced type of asthma known as Reactive airway syndrome (RAS) has occurred in some victims.

ii. **Phosgene:** The extent of the poising depends on how close the victims are to the place where the gas is released, the type, and amount of exposure. Routes of contamination include inhalation, skin/eye contact, and eating/drinking contaminated food or water. According to OSHA, the odor provides insufficient warning of hazardous concentrations. Inhaling low concentrations of Phosgene may initially cause minimal symptoms such as dryness/burning of the throat and cough, which may discontinue once the patient is removed from the source of exposure. However, after a 30 minute up to a 48 hour symptom free interval, some victims may experience rapid worsening of lung function which may include fluid accumulation in the lungs, rapid respiration, or painful cough which may produce frothy white or yellow liquid. Phosgene has also been linked to RAS. Due to any possible accumulation in the lungs, the inadequate supply of oxygen to the body can manifest as damage to the heart and it's important capillaries. If, upon exposure, the victim's skin is wet or moist, it can become irritated and red almost immediately. Liquid Phosgene can result in frostbite. Phosgene vapor can cause redness and tearing of the eye, clouding in the cornea, and perforation. Nausea and vomiting may be experienced. At high levels of exposure, permanent damage to the kidneys and liver can occur. If the victim survives the first 48 hours of exposure, they are likely to survive, but may acquire long term sensitivity to chemical irritants, chronic inflammation and irritation of the bronchioles (lung tubes), emphysema, and increased susceptibility to infections. Workers exposed to daily high levels of the chemical have been shown to have an increased risk of diseases and death associated with long term lung disorders.

CWP-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments

STANDARDS:

1. Discuss the importance of follow-up care
2. Discuss procedure for obtaining follow-up appointments
3. Emphasize the importance of keeping appointments
4. Encourage the patient to seek further management if:
    a. Significant worsening of symptoms occurs
    b. Symptoms last longer than expected

CWP-I INFORMATION

OUTCOME: The patient/family will receive information about chemical weapons as appropriate

STANDARDS:

1. Identify the suspected biological weapon that the patient/family has been exposed to.
    a. **Tabun:** is a clear, colorless, tasteless liquid that has a slight fruity, almond odor attributed to by the formation of hydrogen cyanide. It may contain 5-20 percent chlorobenzene as solvent and stabilizer. The substance can be absorbed into the body by all routes. Usually liquid in normal state, but will volatilize if heated to form vapor or aerosol. As little as 1 to 10 mls can be lethal
    b. **Sarin:** is also a clear, colorless, tasteless liquid, but has no identifiable odor. Sarin is one of the more volatile nerve agents and can easily be transformed in to a gaseous state, rendering it more able to spread through the environment. A persons clothing can release Sarin up to 30 minutes after exposure
    c. **Soman:** is a clear, colorless liquid that has been associated with a camphor or rotting fruit odor. It vaporizes in to air easily.
    d. **VX:** VX is a tasteless oily liquid that is amber in color, and evaporates at a slow rate comparable to the rate at which motor oil would evaporate. Extremely high temperatures are required to make VX evaporate
    e. **Lewisite:** an oily colorless liquid in its pure form that may appear amber to black in its impure form. It has an odor similar to geraniums. Lewisite contains arsenic, and thus has some effects similar to arsenic poisoning, including stomach ailments and low blood pressure.
    f. **Sulfur Mustard:** This can be clear or a yellow-brown colored in its oily liquid or solid state. It can also vaporize and spread through the environment.

SM sometimes smells like garlic, mustard, onions, or nothing at all. It can last in the environment for up to 2 days following release in regular weather conditions, but under very cold conditions, it can last for up to weeks or months.

g. **Nitrogen mustards:** These can be oily liquid, vapor, or solid forms. NM's can smell fishy, musty, soapy, or fruity. They can be clear, pale amber, or yellow in appearance.

h. **Phosgene Oxime:** This is also known as an urticant or nettle agent due to its ability to produce intense itching and rash, similar to hives, when it comes in contact with skin. In the liquid state, it appears to be yellow in color, while in the solid state it is clear. It is known to possess a disagreeable, irritating odor. It does not last in the environment for long as it breaks down within 2 hours in soil, and within a few days within water.

i. **Cyanide:** It is a colorless or pale blue liquid at room temperature. Being very volatile, it can readily produce toxic, flammable concentrations at room temperature. It has a distinct bitter almond odor and the ability to perceive it is a genetic trait (20 to 40% of the general population cannot detect Hydrogen Cyanide).

j. **Clorine:** This is one of the most commonly manufactured chemicals in the US for uses both industrial and household. It can present as a poisonous gaseous form, which can also be cooled, and pressurized in order to store or transport it. Once this liquid is released, it quickly turns in to the gaseous form that spreads relatively fast, and close to the ground. Chlorine gas has a distinct pungent, irritating odor, much like bleach and usually appears to be yellow-green in color at room temperature. At higher pressures, or temperatures below –30F, it is a clear, amber-colored liquid. Though Chlorine gas itself is noncombustible, it is a strong oxidizer that can readily form explosive compounds when it comes in to contact with many common substances. Chlorine gas is highly corrosive when it comes in to contact with any dermal surfaces, i.e., skin, eyes. Pure Chlorine is unlikely to be ingested, for it is a gas at room temperature.

k. **Phosgene**: This is a major industrial chemical used to make plastics and pesticides. At normal room temperature, Phosgene is a poisonous gas. It can be cooled, or pressurized in to a liquid form so that it may be packaged and transported; once opened, it will quickly return to its gaseous state, and spread fast in to the environment close to the ground. The gaseous form may be colorless or pale yellow in color. At low concentrations the gas may smell pleasantly of newly mown hay, but at higher concentrations, it may become a stronger, more unpleasant smell. Phosgene is non-flammable, unless mixed with certain other chemicals.

CWP-L LITERATURE

OUTCOME: The patient/family will receive written information about exposure to chemical weapons.

STANDARDS:

1. Provide the patient/family with written patient information literature about exposure to chemical weapons
2. Discuss the content of the patient information literature with the patient/family

CWP-M MEDICATIONS

OUTCOME: The patient/family will understand the role of medications in the acute treatment of exposure, prophylaxis, and the prevention of disease resulting from exposure to chemical weapons as appropriate.

STANDARDS:

1. Review the medication(s) with the patient. Reinforce the importance of knowing the drug, dose, dosing interval, and duration of medical therapy.
2. Review the common side effects, signs of toxicity, and drug interactions of the medications
3. Emphasize the importance of fully participating in the medication and plan and explain how effective use of medications may reduce symptoms, complications, and prevent death.

CWP-P PREVENTION

OUTCOME: The patient/family will understand actions that may be taken to prevent exposure to and infection with chemical weapons

STANDARDS:

1. Instruct the patient to avoid contact with people or area's suspected of exposure to chemical weapons
2. Instruct patient on the importance of hand washing and maintaining appropriate hygiene
3. Encourage patient to receive recommended medications and/or vaccinations for post-exposure prophylaxis and/or threat of chemical agents as appropriate.
    a. **Nerve Agents:**
        i. Pyridostigmine has been used in preparation for possible future exposure to nerve agents. A 30mg tablet every 8 hours (preferable a total of 21 tabs) are to be taken prior to exposure. NAPP helps protect acetyl cholinesterase from the action of nerve agents, and thus serves only to enhance post exposure prophylaxis.
        ii. Post exposure prophylaxis includes injecting Atropine for its ability to block Ach at muscarinic receptors. Depending on the severity of the symptoms, and the age of the victim, 1 to 4 mg should be administered. 2 PAM Cl is used for its ability to block and reverse the bonding of the nerve agent to acetyl cholinesterase, and victims are injected with 600mg IM. 10mg IM injection of diazepam may be utilized in order to prevent the occurrence of seizures.
    b. **Blistering agents/vesicants:**
        i. There are no known antidotes for these agents and post exposure support i.e., ventilation.
    c. **Blood Agents:**
        i. Sodium Nitrite 300mg IV over 3 minutes and Sodium Thiosulfate 12.5gm IV over a 10minute period in order to sequester and rid the body of Cyanide. Assisted ventilation may also be necessary.
    d. **Pulmonary Agents:**
        i. No current antidotes are available. Supportive therapy must be initiated.

CWP-TE TESTS

OUTCOME: The patient/family will understand the role of testing in appropriate management of exposure to chemical weapons

STANDARDS:

1. Discuss that certain lab tests may be required after exposure to a chemical weapon.
    a. **Nerve Agents:**
        i. RBC cholinesterase activity (severe symptoms usually present with greater than 70% cholinesterase inhibition)
        ii. CXR or pulse oximetry recommended in severe exposures
        iii. Routine labs, i.e., CBC, glucose, electrolytes.
    b. **Blister/Vesicant agents:**
        i. WBC<500 can indicate vesicant exposure
        ii. Routine labs
    c. **Blood Agents:**
        i. Routine labs/pulmonary function
    d. **Pulmonary Agents:**
        i. Routine labs/pulmonary function
4. Discuss why lab tests are used for patient monitoring purposes
5. Explain what test(s) will be ordered. Provide information on the indication, benefits, and risks of the tests.
6. Explain how test results will be used to guide therapy

CWP-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments available after exposure to a chemical weapon

STANDARDS:

1. Explain that the treatment plan will be made by the patient and the health care team after reviewing available options
2. **Nerve Agents:** Atropine should be continued at 5-10 minute intervals, until the adequate resolution of symptoms (Secretions have diminished and breathing is comfortable). Continue Diazepam if required for the prevention of convulsions. Phentolamine (5mg IV for adults, 1mg IV for children) can be used for 2-PAM induced hypertension.
3. **Blister Agents/Vesicants:**
    a. Mustard Blisters: Apply a one-eighth of an inch thick layer of mafenide acetate or silver sulfadiazine cream to be used as a topical anti-bacterial. If the blister worsens to an infected state, appropriate antibiotic therapy should be sought.
    b. Inhalation of Mustards: In cases of severe RT injury, where a pt is infected with a pneumonal infection, aggressive antibiotic therapy is required
    c. Mustard ingestion: In treating systemic symptoms 0.4-0.8 mg SQ Atropine may be useful in reducing GI activity. If the victims' white blood cell count were significantly reduced, isolation and appropriate antibiotic therapy would be needed.
4. **Blood Agents:** See above for post-exposure prophylaxis
5. **Pulmonary Agents:**
    a. Antimicrobial treatment is reserved only for cases of acquired bacterial bronchitis/pneumonitis.
    b. At sufficiently high doses of these agents, pulmonary edema is more than likely to follow. In these cases, large doses of steroids must be administered as soon as possible, preferably started within 15 minutes of exposure.
    c. Dexamethasone Na Phosphate: 4 puffs must be inhaled at the earliest possible time, then 1 puff q 3 mins until irritation has subsided. After this, 5 puffs q 15 minutes to total 150 puffs. Following this, 1 puff q 1h daily, with 5 puffs q 15mins to total 30 puffs in preparation for nighttime sleep. This regimen should be continued for at least 5 days.
    d. For treating life threatening situations, the above inhaled regimen should be supplemented with the following:
        i. Day 1: 1000 mg IV prednisolone
        ii. Day 2: 3800 mg IV prednisolone

iii. Day 3: 5700 mg IV prednisolone

iv. Beginning day 6, systemic CS dose should be reduced, provided the CXR remains clear

e. If the patient is pre-disposed to pulmonary infection complications, adjuvant antibiotic coverage should also be considered.

CP—Chest Pain

CP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand some possible etiologies of chest pain.

STANDARDS:

1. Discuss various etiologies for chest pain, i.e., cardiovascular, pulmonary, musculoskeletal, gastrointestinal.
2. Explain that diagnostic testing may be required to determine the etiology.

CP-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Explain the use of equipment utilized to monitor the patient.
2. Explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
3. Emphasize, as necessary, that electrodes and sensors must be left in place in order for the equipment to function properly.
4. Encourage the patient/family to ask questions if they have concerns regarding equipment readings.
5. Emphasize the importance of not tampering with any medical equipment.

CP-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments and fully participate with instruction given for recurrence of chest pain.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Explain circumstances /examples that should prompt immediate medical attention.
3. Discuss the procedure for obtaining follow-up appointments.
4. Emphasize that appointments should be kept.

CP-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about chest pain.

STANDARDS:

1. Provide the patient/family with written patient information literature on chest pain.
2. Discuss the content of patient information literature with the patient/family.

CP-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and proper use of medications.

STANDARDS:

1. Review the proper use, benefits and common side effects of prescribed medications.
2. Emphasize the importance of maintaining strict participation to the medication regimen.
3. Encourage the patient to carry a list of current medications with them.

CP-N NUTRITION

OUTCOME: The patient/family will understand how nutrition might affect chest pain.

STANDARDS:

1. Discuss as appropriate that some foods might exacerbate chest pain.
2. Refer to a registered dietician as appropriate.

CP-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in chest pain.

STANDARDS:

1. Explain that uncontrolled stress may cause chest pain or increase the severity of other conditions which cause chest pain. **Refer to CAD, GAD.**
2. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as inappropriate eating, all which can contribute to causes of chest pain.
3. Explain that effective stress management may help reduce the frequency of chest pain, as well as help improve the health and well-being of the patient.
4. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
5. Provide referrals as appropriate.

CP-TE TESTS

OUTCOME: The patient/family will understand tests to be performed, the potential risks, expected benefits and the risk of non-testing.

STANDARDS:

1. Explain tests that have been ordered.
2. Explain the necessary benefits and risks of tests to be performed. Explain the potential risk of refusal of recommended test(s).
3. Inform patient of any advance preparation for the test, i.e., NPO status.

CDC—Communicable Diseases

CDC-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the disease process of communicable disease, transmission, and causative agent(s), as identified by the provider.

STANDARDS:

1. Discuss whether the infection is vaccine preventable.
2. Describe how the body is affected.
3. List symptoms of the disease and how long it may take for symptoms to appear.
4. List complications that may result if the disease is not treated.
5. List treatment options and the risks and benefits of each.

CDC-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

CDC-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of communicable diseases and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer future infections (reinfections or reinfestations), fewer emergency room visits, fewer hospitalizations and fewer complications, as well as a healthier life.
3. Explain the relationship between hygiene and infection control principles. Emphasize importance of hand washing.

CDC-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about communicable diseases.

STANDARDS:

1. Provide patient/family with written patient information literature on the communicable diseases.
2. Discuss the content of patient information literature with the patient/family.

CDC - M MEDICATION

OUTCOME: The patient/family will understand the importance of medication in the treatment of the communicable disease and make a plan to fully participate with therapy.

STANDARDS:

1. Discuss the proper use, benefits, common side effects, and food or drug interactions of the prescribed medication. Include procedure for follow-up if problems occur.
2. Explain the importance of completing the course of therapy and its role in eradicating the infection and/or decreasing the infectiousness of the communicable disease.
3. Explain, as appropriate, that failure to complete the course of antibiotics may cause the development of resistant organisms.
4. Discuss, as appropriate, the concomitant use of antipyretics.

CDC-N NUTRITION

OUTCOME: The patient/family will understand the need for balanced nutrition and plan for the implementation of dietary modification if needed.

STANDARDS:

1. Review normal nutritional needs for optimal general health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss nutritional modifications as related to the specific communicable disease.

CDC-P PREVENTION

OUTCOME: The patient and/or family will understand communicability and preventive measures for communicable disease control.

STANDARDS:

1. Explain that there are vaccines or immunity against certain infections and/or diseases.
2. Explain that certain infections can be dependent upon hygiene, social and/or environmental conditions. **Refer to WL-HY.**
3. Discuss importance of hand washing in infection control in relation to food preparation/consumption, childcare, and toilet use.
4. List mode of transmission and precautions to prevent spread of disease.

CDC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient; and may be multifaceted. **Refer to PM**.
2. Explain that short-term use of NSAIDS may be helpful in pain management as appropriate.
3. Explain non-pharmacologic measures that may be helpful with pain control.

CDC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as appropriate, including possible complications that may result from not having the test performed.
3. Explain how the test relates to immunization status and the course of disease treatment/prevention.
4. Explain the meaning of the test results, as appropriate.

CHF—Congestive Heart Failure

CHF-C COMPLICATIONS

OUTCOME: The patient/family will understand how to prevent complications of CHF.

STANDARDS:

1. Discuss common complications of CHF, i.e., pulmonary or peripheral edema, MI, death, inability to perform activities of daily living.
2. Discuss the importance of following a treatment plan including diet, exercise, and medications to prevent complications.
3. Discuss the importance of regular follow-up to prevent complications.
4. Emphasize early medical intervention for signs and symptoms of complications.

CHF-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

CHF-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the causes and symptoms of congestive heart failure.

STANDARDS:

1. Explain that CHF results from the heart not pumping as efficiently as it should. As a result, fluids back up in the extremities (edema) and in the lungs (pulmonary congestion). This back up of fluids causes weight gain. Weight gain should be reported.
2. Explain the cause of CHF as it relates to the patient's condition, i.e., previous M.I., long-standing hypertension.
3. Review signs and symptoms of CHF, i.e., swelling, fatigue, shortness of breath, weight gain.

CHF-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment, as appropriate.
3. Discuss and/or demonstrate proper use and care of medical equipment. Participate in a return demonstration by the patient/family.
4. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
5. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
6. Emphasize the importance of not tampering with any medical device.
7. Discuss as appropriate the proper use and care and cleaning of medical equipment.
8. Discuss proper disposal of associated medical supplies.

CHF-EX EXERCISE

OUTCOME: The patient/family will understand the exercise recommendations or limitations for this patient's disease process.

STANDARDS:

1. Discuss the exercise recommendations or limitations of exercise for this patient.
2. Emphasize the importance of seeking medical advice before starting/changing any exercise program.

CHF-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of fully participating in treatment regimen and keeping all follow-up appointments.

STANDARDS:

1. Discuss the individual's responsibility in the management of CHF.
2. Encourage regular weight checks and the reporting of any sudden weight gain.
3. Explain the procedure for making follow-up appointments.
4. Review treatment plan with the patient, emphasizing the need for keeping appointments, fully participating in medication regimen, keeping to dietary modifications, and striving to maintain activity/rest balance.

CHF-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of congestive heart failure and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan. (Attain or maintain a healthy weight, eliminate tobacco use, control alcohol intake, elevate feet to reduce edema, etc.)
2. Explain the importance of following a home management plan, i.e., fewer emergency room visits, fewer hospitalizations and fewer complications, as well as a healthier life.
3. Explain the relationship between congestive heart failure and the increased risk of a MI, PE, and/or stroke.
4. Discuss the importance of avoiding communicable diseases by avoiding contact with ill persons, and by obtaining vaccination for vaccine preventable diseases.
5. Balance activity and rest.

CHF-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about congestive heart failure.

STANDARDS:

1. Provide patient/family with written patient information literature on the congestive heart failure.
2. Discuss the content of patient information literature with the patient/family.

CHF-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle adjustments necessary to maintain control of congestive heart failure and formulate an adaptive plan with assistance of the provider.

STANDARDS:

1. Discuss lifestyle changes that may reduce the symptoms of heart failure and improve quality of life. (Attain or maintain a healthy weight, eliminate tobacco use, control alcohol intake, elevate feet to reduce edema, etc.)
2. Discuss the importance of avoiding communicable diseases by avoiding contact with ill persons, and by obtaining vaccination for vaccine preventable diseases.
3. Balance activity and rest.

CHF-M MEDICATIONS

OUTCOME: The patient will understand the importance of following a prescribed medication regimen.

STANDARDS:

1. Review proper use, benefit, and common side effects of the prescribed medications.
2. Emphasize the importance of maintaining full participation in the medication regimen.

CHF-N NUTRITION

OUTCOME: The patient will develop a plan to control CHF through weight control and sodium intake modification.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between sodium and fluid retention.
3. Emphasize the importance of a sodium-restricted diet.
4. Provide a list of foods high in sodium and emphasize the importance of reducing sodium intake. Refer to registered dietician or other local resources as available.
5. Assist in developing appropriate diet plan to achieve optimal weight and sodium control.

CHF-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in congestive heart failure.

STANDARDS:

1. Explain that uncontrolled stress can increase the severity of congestive heart failure.
2. Explain that uncontrolled stress can interfere with the treatment of congestive heart failure.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality from congestive heart failure.
4. Explain that effective stress management may help reduce the severity of congestive heart failure, help prevent progression of cardiovascular disease, as well as help improve the health and well-being of the patient.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

CHF-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Discuss the necessity, benefits and risks of the test to be performed, as appropriate, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Discuss the meaning of the test results, as appropriate.

CAD—Coronary Artery Disease

CAD-C COMPLICATIONS

OUTCOME: The patient will understand how to prevent complications of coronary artery disease.

STANDARDS:

1. Discuss the common and important complications of coronary artery disease, i.e., MI, angina, and stroke.
2. Discuss the importance of following a treatment plan to include diet, exercise, and medication therapy to prevent complications.
3. Emphasize immediate medical intervention for signs and symptoms of complications, i.e., chest pain, nausea, loss of consciousness, jaw/arm pain, SOB, diaphoresis.

CAD-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

CAD-DP DISEASE PROCESS

OUTCOME: The patient will understand coronary artery disease and its symptoms.

STANDARDS:

1. Explain that coronary artery disease is the result of the buildup of plaque in the interior wall of the coronary artery.
2. Review the factors related to the development of coronary artery disease - uncontrolled hypertension, elevated cholesterol, obesity, uncontrolled diabetes, sedentary lifestyle, increasing age, family history of vascular disease, and male sex. Emphasize that a personal history of any vascular disease greatly increases the risk or CAD.
3. Review the signs of coronary artery disease - substernal chest pain radiating to the jaw(s), neck, throat, arm(s), shoulder(s), or back. Nausea, weakness, shortness of breath, or diaphoresis (sweating) may accompany the pain.
4. Explain that chest pain is the discomfort felt when the heart muscle is deprived of oxygen.
5. Differentiate between angina (the temporary loss of oxygen to the heart muscle) and infarction (a permanent loss of oxygen to the heart muscle resulting in permanent damage and loss of function). Emphasize that angina is an important warning sign which should prompt immediate medical evaluation.
6. Explain that sometimes only a physician, through test interpretation, may be able to differentiate between angina and myocardial infarction.

CAD-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use and care of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Emphasize safe use of equipment.
7. Discuss proper disposal of associated medical supplies.
8. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
9. Emphasize the importance of not tampering with any medical device.

CAD-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in this patient's disease process and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
2. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
3. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
4. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
5. Discuss medical clearance issues for physical activity.

CAD-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of adhering to a treatment regimen, be able to identify appropriate actions to take for symptoms indicating life-threatening ischemia, and will make a plan to obtain and keep appropriate follow-up appointments.

STANDARDS:

1. Discuss the individual's responsibility in the management of coronary artery disease.
2. Review treatment plan with the patient, emphasizing the need for keeping appointments, fully participating with medication therapy, adhering to dietary modifications, and maintaining an appropriate activity/rest balance.
3. Review the symptoms that should be reported and maintained (symptoms more frequent or occurring during rest, symptoms lasting longer, using prn medications more frequently, etc.).
4. Instruct the patient that if chest pain is not relieved after taking three doses of nitroglycerine 3-5 minutes apart, he/she should go immediately to the nearest emergency care facility. Recommend use of the local emergency transport system.

CAD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about coronary artery disease.

STANDARDS:

1. Provide patient/family with written patient information literature on coronary artery disease.
2. Discuss the content of patient information literature with the patient/family.

CAD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adaptations necessary to maintain optimal health.

STANDARDS:

1. Emphasize that the most important component in the prevention and treatment of coronary artery disease is the patient's adaptation to a healthier, lower risk lifestyle.
2. Discuss lifestyle adaptations that may reduce further risk of myocardial infarction and improve the quality of life (cease use of tobacco products, limit stress, control hypertension and elevated cholesterol through medications, diet and exercise, lose weight as indicated, control diabetes, and increase activity as prescribed by the physician).

CAD-M MEDICATIONS

OUTCOME: The patient will understand the importance of following a prescribed medication regimen.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medications.
2. Emphasize the importance of maintaining full participation in the medication regimen.

CAD-N NUTRITION

OUTCOME: The patient/family will understand how to control coronary artery disease through weight control and diet modification and develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between diet and coronary artery disease, hypertension, elevated cholesterol, and obesity.
3. Provide lists of foods that are to be encouraged and avoided. Refer to dietitian or other local resources as appropriate.
4. Assist in developing an appropriate diet plan to achieve optimal weight and cholesterol control.
5. **Refer to LIP**.

CAD-P PREVENTION

OUTCOME: The patient/family will understand ways to prevent CAD.

STANDARDS:

1. Discuss that prevention of coronary artery disease is far better than controlling the disease after it has developed.
2. Explain that consuming a diet low in fat, and controlling weight, lipid levels and blood pressure will help to prevent CAD.
3. Discuss that persons with uncontrolled diabetes and uncontrolled hypertension and uncontrolled dyslipidemia are more likely to develop CAD. Stress the importance of controlling these disease processes. **Refer to DM, HTN, LIP, OBS.**

CAD-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that chest pain unrelieved by the prescribed regimen should be considered an emergency and prompt immediate medical evaluation.
2. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM.**
3. Explain that short-term use of narcotics may be helpful in pain management as appropriate.
4. Explain that other medications may be helpful to control the symptoms of pain.
5. Discuss non-pharmacologic measures that may be helpful with pain control.

CAD-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure(s), as well as the risks, benefits, alternatives to the proposed procedure(s) and associated factors affecting the patient.

STANDARDS:

1. Explain the specific procedure(s) to be performed, including the risks and benefits of performing the procedure and the adverse events that might result from refusal of the procedure.
2. Discuss alternatives to the proposed procedure(s), including expectant management, as appropriate.
3. Discuss the expected patient/family involvement in the care required following the proposed procedure(s).

CAD-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in coronary artery disease.

STANDARDS:

1. Explain that uncontrolled stress can increase the severity of coronary artery disease.
2. Explain that uncontrolled stress can interfere with the treatment of coronary artery disease.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality from coronary artery disease.
4. Explain that effective stress management may help reduce the severity of coronary artery disease, as well as help improve the health and well-being of the patient.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

CAD-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Explain the test ordered (ECG, echo, thallium stress test, coronary angiography).
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment.

CAD-TX TREATMENTS

OUTCOME: The patient/family will understand the possible treatments that might be performed based on the test results.

STANDARDS:

1. List the possible procedures that might be utilized to treat the coronary artery blockage, i.e., angioplasty, coronary stent, coronary artery bypass.
2. Briefly explain each of the possible treatments.
3. Explain that the patient and medical team will make the treatment decision after reviewing the results of diagnostic tests.

CRP—Croup

CRP-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and important complications associated with croup.

STANDARDS:

1. Discuss that complications occur in a minority of patients and include otitis media or pneumonia. The most serious complication is worsening airway obstruction which may lead to respiratory failure.
2. Review with the patient/family the signs of complications, i.e., rapid breathing, nasal flaring, retractions, stridor at rest; bluish color on his/her lips or face; drooling, trouble swallowing; prolonged fever; dehydration, pulling at ears.

CRP-DP DISEASE PROCESS

OUTCOME: The patient will understand the etiology and pathophysiology of croup.

STANDARDS:

1. Review the anatomy and physiology of the throat and lungs.
2. Explain that croup is a swelling of the upper airway in the area commonly called the windpipe (trachea), and voice box (larynx) and sometimes the bronchial tree. The medical term for croup is laryngotracheobronchitis.
3. Explain that *most* children with croup have a virus. Several types of viruses may cause this infection but the most common cause is a virus called parainfluenza. Croup-like symptoms can also be caused by allergies, trauma, congenital anomalies of the airway or foreign bodies in the airway. Hemophilus influenza, a bacteria, can lead to stridor (noisy vibratory sound on inspiration) and is often more serious than croup (children are protected if immunized against *Hemophilus influenza B).*
4. Explain that croup most often occurs in children between 6 months and 3 years of age during the cold season and is more common in boys. Croup may begin suddenly and is generally worse at night. Viral croup usually goes away in 3 to 7 days.
5. Discuss that the recognizable barking cough and noisy breathing (stridor) is caused by the swelling in the upper airway. The cough may be bad enough to cause gagging or vomiting. Patients may also have a runny nose, hoarse voice, and/or fever. The worst of the illness lasts 2-3 days. Be alert for signs of complications.

CRP-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use and care of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Emphasize safe use of equipment.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

CRP-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of follow-up care and will strive to keep scheduled appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Review the signs/symptoms (drooling, extremely ill appearance, altered level of consciousness, blue color or extreme difficulty breathing) that require immediate attention and return to the clinic or emergency room.

CRP-HM HOME MANAGEMENT

OUTCOME: The patient and/or family will understand the home management of croup.

STANDARDS:

1. Discuss how to care for the child at home and the importance of following the home management plan. Explain that home management of croup focuses on the relief of symptoms.
2. Explain that crying and anxiousness make croup worse by causing additional tightness around the windpipe. Parents should remain calm, which will help the child to stay calm. Cuddle and comfort the child.
3. Explain that the child will usually sit in a position that makes breathing easy. Do not force the child to lie down if he/she wants to sit up.
4. Discuss the use of non-pharmacologic therapies that may be useful in symptom relief:
    a. Warm or cool humidifier (don't use a hot vaporizer)
    b. "Foggy bathroom treatment" (mist up the bathroom with hot shower steam, and have the child sit outside of the shower in the bathroom for up to 20 minutes while cuddling or reading to the child)
    c. Taking the child into the cool outside air for about 15 minutes.
    d. Drinking warm, clear liquids may loosen mucus and ease breathing (may not be appropriate for young infants).
5. Emphasize the importance of a smoke free environment, since smoke can make croup worse.
6. Discuss that it may be appropriate for the parent to sleep in the same room with the child until the symptoms become less severe.

CRP-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about croup.

STANDARDS:

1. Provide the patient/family with written patient information literature on croup.
2. Discuss the contents of the patient information literature with the patient/family.

CRP-M MEDICATIONS

OUTCOME: The patient/family will understand that antibiotics do not cure viral infections and that medications that are used for croup are used for symptomatic relief.

STANDARDS:

1. Explain that most croup is caused by a virus and that antibiotics are not effective.
2. Discuss the use of antipyretics for fever reduction as applicable. **Refer to F.**
3. Discuss the use of steroids or nebulized treatments in relief of swelling associated with croup as applicable.
4. Discuss that cough medicines are of very little or no value in the treatment of the cough associated with croup.

CRP-SHS SECOND-HAND SMOKE

OUTCOME: Provide the patient and/or family with an understanding of the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls
2. Discuss harmful substances in smoke:
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances)
3. Explain the increased risk of illness in the croup patient when exposed to cigarette smoke either directly or via second-hand smoke.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage smoking cessation or at least never smoking in the home or car.

D

DEH—Dehydration

DEH-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of untreated dehydration.

STANDARDS:

1. Explain that untreated, severe dehydration can lead to shock and damage to vital organs such as the kidneys. This may result in death.

DEH-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the specific cause of the patient's dehydration and its symptoms.

STANDARDS:

1. Explain that dehydration occurs when the body loses too much fluid or fluid losses are not replaced.
2. Discuss the possible causes of dehydration - strenuous exercise, vomiting, diarrhea, profuse diaphoresis, draining wounds, ketoacidosis, hemorrhage, prolonged heat exposure.
3. Enumerate some of the symptoms of dehydration, i.e., weight loss; thirst; poor skin turgor; dry skin, dry mucous membranes and tongue; soft and sunken eyeballs; sunken fontanels in infants; apprehension and restlessness or listlessness; concentrated urine, low-grade fever; lack of tears, headache, irritability.
4. Explain that tired muscles, leg cramps or faintness are signs of more severe dehydration that can progress to hypovolemic shock.
5. Explain that consumption of caffeinated or sugared beverages may cause or contribute to dehydration and should not be substituted for water intake.
6. Discuss groups that are at higher than average risk for dehydration:
    a. infants and small children
    b. elderly individuals
    c. severely disabled or mentally retarded individuals
    d. pregnant women
    e. gastric bypass patients

DEH-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
4. Emphasize the importance of not tampering with any medical device.

DEH-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of regular follow-up and keep follow-up appointments. The patient/family will develop a plan to manage dehydration.

STANDARDS:

1. Emphasize that the treatment plan and full participation to it are the responsibility of the patient/family.
2. Stress the importance of keeping follow-up appointments and continuing the prescribed therapy as indicated.
3. If the patient is treated as an outpatient, instruct to return if symptoms do not improve, get worse, or additional symptoms develop.

DEH-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information regarding dehydration and its treatment.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding dehydration and its treatment.
2. Discuss the content of the patient information literature with the patient/family.

DEH-P PREVENTION

OUTCOME: The patient/family will understand and develop a plan to prevent the development of dehydration.

STANDARDS:

1. Explain that babies, small children, pregnant women and older adults are at increased risk for dehydration and extra care needs to be taken to prevent dehydration.
2. Explain that taking/giving adequate water or oral electrolyte solutions (not sports drinks, caffeinated beverages, or alcoholic beverages) is essential to the prevention of dehydration, particularly in a hot/humid environment or during strenuous activity.
3. Explain that clothing that contributes to excessive sweating may cause dehydration.
4. Explain that sometimes it is necessary to replace fluids with liquids containing electrolytes to prevent dehydration with electrolyte abnormalities.

DEH-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed including indications and impact on further care.

STANDARDS:

1. Explain that a complete blood count, electrolytes and urinalysis are common tests ordered to evaluate the extent and effect of dehydration on the body.
2. Explain that these tests will give valuable information regarding the type and route of rehydration that is necessary and further tests that may be necessary to determine the cause and effects of the dehydration and to evaluate treatment.
3. Explain that a blood and/or a urine sample will be obtained for these tests.
4. Explain the results and indications of these tests and any others performed.

DEH-TX TREATMENTS

OUTCOME: The patient/family will understand the treatment for dehydration.

STANDARDS:

1. Explain that the treatment plan for dehydration is fluids. However, the type, rate, amount and delivery mode of the fluids will depend on the cause and severity of the dehydration.
2. Usually, fluid replacement will include electrolytes. Commercial rehydration solutions may be advised (Pedialyte, Infalyte, or other balanced electrolyte solutions). **Refer to GE-TX**.
3. Discourage the use of caffeinated beverages because they are mild diuretics and may lead to increased loss of water and sodium.
4. Discourage the use of alcoholic beverages (including beer and wine coolers) as they actively dehydrate via enzymatic activity.
5. Explain that the fluid replacement via the intravenous route may be necessary if dehydration is severe or oral fluids are not tolerated.

DIV—Diverticulitis / Diverticulosis

DIV-C COMPLICATIONS

OUTCOME: The patient/family will understand the signs of complications and will plan to return for medical care if they occur.

STANDARDS:

1. Explain that some possible complications of diverticulosis and diverticulitis may include hemorrhage, abscess development and perforation with peritonitis, bowel obstruction, intussusception, and volvulus.
2. Advise the patient to seek immediate medical care for any signs of complications, such as lower abdominal cramping, abdominal distention fever, malaise, hemorrhage.

DIV-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of diverticulitis/diverticulosis.

STANDARDS:

1. Explain that a diverticulum is a pouch or saccular dilatation from the main bowel cavity. Diverticulosis is the condition in which an individual has multiple diverticulae. Diverticulitis is an inflammation of one or more diverticulae.
2. Explain that- some of the- predisposing factors may include congenital predisposition, weakening and degeneration of the muscular wall of the intestine, chronic over distention of the large bowel, and a diet low in roughage.
3. Explain that diverticulosis develops in nearly 50% of persons over age 60, but only a small percentage develops diverticulitis.
4. Explain that diverticulosis-ma-y be accompanied by minor bowel irregularity, constipation and diarrhea.
5. Explain that symptoms of diverticulitis may range from mild abdominal soreness and cramps with "gas" and low grade fever, to more severe cramping and pain accompanied by fever, chills, nausea, abdominal rigidity and massive hemorrhage.
6. Inform the patient that diverticulitis may be acute or chronic.

DIV-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

DIV-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about diverticulitis and or diverticulosis.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding diverticulitis and/or diverticulosis.
2. Discuss the content of the patient information literature with the patient/family.

DIV-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication regimen and make a plan to take the medication as prescribed.

STANDARDS:

1. Describe the proper use, benefits, and common or important side effects of the patient's medications. State the name, dose, and time for administration as applicable.
2. Discuss any significant drug/drug or drug/food interactions, including interaction with alcohol.
3. Discuss with the patient/family the need to complete the full course of antibiotics, as prescribed (when indicated.)
4. Caution the patient/family against utilizing over-the-counter medications for constipation without consulting his/her provider.

DIV-N NUTRITION

OUTCOME: The patient/family will understand how dietary modification may assist in the control of bowel function and develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.
2. Emphasize the hazards of constipation.
3. Explain that during periods of acute inflammation, it may be necessary to begin with a very restricted diet and slowly progress to a bland diet.
4. Explain that bulk can be added to stools by eating fruits and vegetables with a high fiber content (seedless grapes, fresh peaches, carrots, lettuce).
5. Encourage a diet that is high in fiber and low in sugar to maintain intestinal tract function. Advise to avoid indigestible roughage, such as celery and corn.
6. Provide list of appropriate foods that are high in fiber and low in sugar.
7. Advise the patient/family to avoid extremely hot or cold foods and fluids, because they may cause flatulence. Also, alcohol, which irritates the bowel, should be avoided. Stress the importance of thoroughly chewing all foods.
8. Assist the patient/family in developing appropriate meal plans.
9. Stress the importance of water in maintaining fluid balance and preventing constipation.
10. Refer to dietitian as appropriate.

DIV-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of diverticulitis and/or diverticulosis.

STANDARDS:

1. Discuss the effects of a fatty, low fiber diet on the colon.
2. Provide and review a list of low fat, high fiber foods.
3. Assist the patient/family in meal planning that includes low fat, high fiber foods and avoids high fat, low fiber foods.
4. Explain that the etiology of Crohn's disease is unknown and there is no known prevention, but an appropriate diet may prevent or slow progression of the disease.

DIV-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that diverticulitis with pain usually responds to a liquid or bland diet and stool softeners to relieve symptoms, minimize irritation, and decrease the spread of the inflammation.
2. Discuss the plan for pain management during the acute phase, which may include opiate or non-opiate analgesics and anticholinergic to decrease colon spasms.
3. Advise the patient not to use over the counter pain medications without checking with his/her provider.
4. Discuss non-pharmacologic methods of pain control as appropriate.

DIV-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Proctosigmoidoscopy and Colonoscopy
   a. Explain that proctosigmoidoscopy and colonoscopy may be utilized to directly visualize the inside of the colon and enable biopsies to be obtained. The information from the colonoscopy may be necessary to diagnose the specific type of bowel disease.
   b. Explain that the procedure involves introducing a flexible tube through the anus and rectum.
   c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.
2. Barium Enema
   a. Explain that the barium enema is an x-ray to assess the extent of the disease, identify lesions, detect pseudo polyps, carcinoma, and strictures.
   b. Explain that barium liquid will be introduced by enema and radiographs taken.
   c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.

DIV-TX TREATMENT

OUTCOME: The patient/family will understand the prescribed treatment for diverticulitis/diverticulosis and have a plan to fully participate in the treatment regimen.

STANDARDS:

1. Discuss the specific treatment plan, which may include the following:
   a. During acute episodes, nothing by mouth and IV fluid and nutritional support may be necessary in order to rest the bowel
   b. Liquid or bland diet during the less acute phase, then a high fiber diet to counteract the tendency toward constipation
   c. Stool softeners
   d. Antimicrobial therapy to combat infection
   e. Antispasmodics to control smooth muscle spasms
   f. Surgical resection of the area of involved colon and sometimes temporary colostomy
2. Advise the patient to avoid activities that raise intra-abdominal pressure, i.e., straining during defecation, lifting, coughing.
3. Discourage smoking, as it irritates the intestinal mucosa.

DV—Domestic Violence

DV-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

DV-DP DISEASE PROCESS

OUTCOME: Patient/family will understand that domestic violence is a primary, chronic, and preventable disease.

STANDARDS:

1. Discuss the patient/family member's abusive/violent disorder.
2. Discuss the patient's and family members' attitudes toward their dependency.
3. Explain co-dependency as it relates to domestic violence.
4. Identify risk factors and "red flag" behaviors related to domestic violence.
5. Discuss the role of alcohol and substance abuse as it relates to domestic violence.
6. Explain that the natural course of domestic violence is one of escalation and that without intervention it will not resolve.

DV-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

DV-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about domestic violence.

STANDARDS:

1. Provide patient/family with written patient information literature on domestic violence.
2. Discuss the content of patient information literature with the patient/family.

DV-P PREVENTION

OUTCOME: The patient/family will understand risk factors and behaviors that predispose to domestic violence and develop a plan to avoid relationships and situations which may result in domestic violence.

STANDARDS:

1. Explain predisposing risk factors for domestic violence, including a pathological need for control, alcohol and/or substance abuse, history of child abuse and/or domestic violence in the family of origin, etc.
2. Explain that environmental stressors, physiologic changes, and illnesses may precipitate violent behavior in persons who are predisposed to violent behaviors.
3. Discuss the progression of domestic violence from verbal/emotional abuse such as shouting and name-calling to physical violence such as shoving to injury and death.
4. Explain that the natural course of domestic violence is one of escalation and that without intervention it will not resolve.
5. Develop a plan of care to avoid violent relationships.

DV-PSY PSYCHOTHERAPY

OUTCOME: The patient will understand the goals and process of psychotherapy.

STANDARDS:

1. Emphasize that for the process of psychotherapy to be effective they must keep all their appointments. Emphasize the importance of openness and honesty with the therapist.
2. Explain to the patient that the therapist and the patient will jointly establish goals, ground rules, and duration of therapy.

DV-S SAFETY AND INJURY PREVENTION

OUTCOME: Patient, family members, and other victims will understand the pattern of domestic violence, make a plan to end the violence, develop a plan to insure safety of everyone in the environment of violence, and implement that plan as needed.

STANDARDS:

1. Be sure family members and other victims are aware of shelters and other support options available in their area. Make referrals as appropriate.
2. Review co-dependency. **Refer to DV-DP**.
3. Assist to develop a plan of action that will insure safety of all people in the environment of violence.

DV-SCR SCREENING

OUTCOME: The patient/family will understand the screening device.

STANDARDS

1. Explain the screening device to be used.
2. Explain why the screening is being performed.
3. Discuss how the results of the screening will be used.
4. Emphasize the importance of follow-up care.

DV-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in domestic violence.

STANDARDS:

1. Explain that uncontrolled stress often exacerbates domestic violence.
2. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use, all of which can increase the risk of domestic violence.
3. Emphasize the importance of seeking professional help as needed to reduce stress.
4. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
5. Provide referrals as appropriate.

DV-TX TREATMENT

OUTCOME: The patient/family will understand that domestic violence as a chronic disease will require long-term intervention which may include psychotherapy, medication, and support groups.

STANDARDS:

1. Review the nature of domestic violence as a primary, chronic, and treatable disease.
2. Explain that both patient and family need to acknowledge, admit, and request help.
3. Review treatment options available, including individual, family counseling, group advocacy, etc.

DYS—Dysrhythmias

DYS-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the anatomy and physiology of the heart and cardiac conduction system.

STANDARDS:

1. Explain that there are two atria, or upper chambers of the heart that receive blood from the lungs and body and contract at the same time to force blood into the lower chambers of the heart. Explain that there are two ventricles, or lower chambers of the heart that receive blood from the upper chambers of the heart and contract at the same time to force blood to the lungs and body.
2. Explain that there is special tissue in the heart that acts as a pacemaker and stimulates the heart to contract. Explain that there is also special tissue that conducts the normal impulses through the heart.
3. Explain that when there is a malfunction, the normal pacemaker may not work properly, other pacemakers may initiate abnormal impulses or the impulses may not be conducted properly. Explain that any of these may cause abnormal heart rhythms.

DYS-C COMPLICATIONS

OUTCOME: The patient will be able to relate the possible complications, the symptoms that should be reported immediately, and the appropriate actions to prevent complications.

STANDARDS:

1. Discuss the possible complications of the particular dysrhythmia, e.g. angina, stroke, CHF.
2. List the symptoms that should be reported immediately, i.e., shortness of breath, dizziness, chest pain, increased fatigue, loss of consciousness.
3. Discuss anticoagulant therapy if appropriate.

DYS-DP DISEASE PROCESS

OUTCOME: The patient will understand what the dysrhythmia is and the signs of the dysrhythmia.

STANDARDS:

1. Review the anatomy and physiology of the heart in relation to the patient's dysrhythmia.
   a. Relate how the dysrhythmia occurs.
   b. Describe the symptoms of the dysrhythmia.
   c. List the symptoms that should be reported immediately, i.e., shortness of breath, dizziness, chest pain, increased fatigue, loss of consciousness.

DYS-EQ EQUIPMENT

OUTCOME: The patient/family will understand the proper use and care of home medical equipment.

STANDARDS:

1. Emphasize the importance of following the prescribed check up and maintenance schedule for implanted or other home equipment.
2. Explain any limitations imposed by the equipment, i.e., exposure to magnetic fields, MRIs, microwaves.

DYS-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of fully participating in the treatment regimen and keeping appointments for follow-up.

STANDARDS:

1. Discuss the individual's responsibility in the management of the dysrhythmia.
2. Explain the procedure for making follow-up appointments.
3. Review the treatment plan with the patient, emphasizing the need for keeping appointments and fully participating in the medication regimen.

DYS-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about dysrhythmia.

STANDARDS:

1. Provide patient/family with written patient information literature on dysrhythmia.
2. Discuss the content of patient information literature with the patient/family.

DYS-M MEDICATIONS

OUTCOME: The patient will understand the type of medication being used, the prescribed dosage and administration of the medication and will understand the importance of following a prescribed medication regimen.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication(s).
2. Emphasize the importance of maintaining full participation in the medication regimen and monitoring schedule.
3. Emphasize the importance of possible drug interactions with foods, drugs and over the counter medications.

DYS-PRO PROCEDURES

OUTCOME: The patient/family will have a basic understanding of the proposed procedure(s), as well as the risks, benefits, alternatives to the proposed procedure(s) and associated factors affecting the patient.

STANDARDS:

1. Explain the specific procedure(s) to be performed, including the risks and benefits of performing the procedure and the adverse events which might result from refusal of the procedure.
2. Discuss alternatives to the proposed procedure(s), including expectant management, as appropriate.
3. Discuss the expected patient/family involvement in the care required following the proposed procedure(s).

DYS-TE TESTS

OUTCOME: The patient will understand the test to be performed and the reasons for the testing.

STANDARDS:

1. Explain the test(s) ordered, i.e., ECG, echo, treadmill, electrophysiological mapping.
2. Explain the indications, risks, and benefits of the test(s).
3. Explain the test as it relates to planning the course of treatment.

DYS-TX TREATMENT

OUTCOME: The patient/family will understand the therapy and the goal(s) of treatment.

STANDARDS:

1. Review the patient's medications. Reinforce the importance of knowing the drug, dose, and dosing interval of the medications, side effects, signs of toxicity, and drug interactions.
2. Emphasize the importance of maintaining full participation in the medication regimen.
3. Explain other treatment options as appropriate (synchronized cardioversion, transcutaneous pacemaker, transvenous pacemaker, or permanent pacemaker).

E

ECZ—Eczema/Atopic Dermatitis

ECZ-C COMPLICATIONS

OUTCOME: The patient/family will be able to recognize common and important complications, the symptoms should be reported immediately, and appropriate intervention(s) taken to prevent complications.

STANDARDS:

1. Discuss the possible symptoms that can lead to complications, i.e., painful dry, red skin rash that itches or is cracked, blisters, peeling, tender, or oozing skin.
2. Review the effects of skin rashes that get out of control, i.e., pain, swelling, redness, drainage, or a fever. **Refer to SWI**.
3. Emphasize that permanent scarring or hair loss may develop if not treated early.
4. Relate that there is no cure for eczema, however, flare-ups can be treated and controlled.

ECZ-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of atopic dermatitis and eczema.

STANDARDS:

1. Briefly review the anatomy/physiology and how it relates to the protective functions of the skin.
2. Discuss that atopic dermatitis and eczema is a name given to a group of skin problems that share a pattern of changes in the surface of the skin.
3. Discuss that atopic dermatitis or eczema can begin in infancy, can last for years and can often be successfully controlled.
4. Discuss the many risk factors for eczema/atopic dermatitis including family history of asthma, food allergies, stress, and things your skin touches such as plants and animals.
5. Discuss that seasonal flare-ups are common.
6. Explain how dryness and itching can cause breaks in the skin and allow bacteria to enter the body.
7. Emphasize the importance of keeping nails cut short to help prevent breaking the skin from scratching. Bacteria are common under fingernails and can cause skin infection from scratching.
8. Discuss the importance of daily hygiene and skin inspection.
9. Explain that use of mild, non-drying, unscented soaps, avoiding very hot water and the use of moisturizing lotion or cream after bathing are all helpful. Perfumes in soaps and lotions may make eczema or atopic dermatitis worse.
10. List symptoms that need to be reported immediately: skin infection, pain, swelling, redness, a thick or colored drainage, or a fever.

ECZ-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the family's understanding of how to obtain follow-up appointments. Correct any misinformation.
3. Emphasize the importance of keeping follow-up appointments.

ECZ-L PATIENT INFORMATION LITERATURE

OUTCOME: The family/patient will receive written information about eczema/atopic dermatitis.

STANDARDS:

1. Provide family/patient with written patient information literature about eczema/atopic dermatitis.
2. Discuss content of the patient information literature with the patient/family.

ECZ-M MEDICATIONS

OUTCOME: The patient/family will understand the importance of full participation with the prescribed medication regimen.

STANDARDS:

1. Discuss the reason for specific medication, treatment, and environmental changes needed to treat this patient's condition.
2. Review directions for use of medication and duration of therapy.
3. Discuss expected benefits of therapy and the important and common side effects.
4. Discuss warning signs to report to the doctor.
5. Discuss the importance of fully participating with medication regimen.
6. Advise that both topical and oral medications can trigger a skin reaction like hives or sunburn. Warn to be alert for any reactions to new medications. Advise patient/family to call a provider to get a substitute medication if a reaction occurs.
7. Emphasize the importance of follow-up.

ECZ-N NUTRITION

OUTCOME: The patient/family will understand nutritional factors that may affect atopic dermatitis or eczema.

STANDARDS:

1. Discuss that some foods may affect atopic dermatitis or eczema. Common triggers are milk products, egg products or wheat products.
2. Refer to a registered dietician as appropriate.

ECZ-P PREVENTION

OUTCOME: The patient/family will understand the appropriate measures to prevent eczema and atopic dermatitis flare-ups.

STANDARDS:

1. Discuss that breast-fed infants are less likely to develop atopic dermatitis or eczema.
2. Discuss avoiding exposure to extreme temperatures, dry air, pet danders, harsh soaps, and bubble baths.
3. Consider the use of cotton blankets and clothing, rather than more irritating fabrics such as wool, or stiff synthetics like polyester.
4. Explain the importance of good hygiene and protection of skin by patting dry after shower or bath to leave some moisture on the skin. Instruct to apply a moisturizing cream, lotion or ointment immediately after bathing to retain moisture in the skin.
5. Explain that skin care products which contain alcohol, perfumes, dyes or allergens may actually worsen the condition.
6. Discuss the importance of avoiding skin contact with irritating chemicals, plants, jewelry, and other substances that trigger skin allergies and dermatitis.
7. Explain that a room humidifier will add moisture to indoor air during the winter heating season.

ECZ-WC WOUND CARE

OUTCOME: The patient/family will understand the necessity and procedure for proper wound care and infection control measures. As appropriate they will demonstrate the necessary wound care techniques.

STANDARDS:

1. Explain the rationale for appropriate care to the wound, i.e., decreased infection rate, improved healing.
2. Demonstrate and explain the correct procedure for caring for this patient's wound. Ask for a return demonstration if needed.
3. Describe signs and symptoms that would require immediate follow-up, i.e., increasing redness, purulent discharge, fever, increased swelling, or pain.
4. Detail the supplies necessary for care of this wound and how/where they may be obtained and the proper methods for disposal of contaminated supplies.
5. Emphasize the importance of follow-up.

EOL—End of Life

EOL-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

EOL-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology, symptoms and prognosis of his/her illness.

STANDARDS:

1. Explain the basic anatomy and physiology of the patient's disease and the effect upon the body system(s) involved.
2. Discuss signs/symptoms of worsening of the patient's condition and when to seek medical care.

EOL-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate (when appropriate) proper use and care of medical equipment.

STANDARDS:

1. Discuss indications for and benefits of prescribed medical equipment to be used during the hospital stay and after discharge, as appropriate.
2. Discuss and/or demonstrate proper use and care of medical equipment, including safety and infection control principles.
3. Assist in return demonstration by patient/family.

EOL-GP GRIEVING PROCESS

OUTCOME: The patient/family will understand the grieving process, recognize the sense of loss, and embrace the importance of preparing for the end of life emotionally and spiritually.

STANDARDS:

1. Explore the various losses and feelings that affect the patient and his/her loved ones when faced with a terminal illness. Explain that grief and a sense of loss become more intense when a patient is dying.
2. Discuss fears, myths and misconceptions of the dying process with the patient/family.
3. Discuss the importance of keeping open communication and promoting social interaction in preserving the dignity of the patient.
4. Explain that the five major losses experienced by a dying patient are; loss of control, loss of identity, loss of achievement, loss of social worth, and loss of relationships.
5. Explore how separation and mourning are aspects of the bereavement process.
6. Explain that bereavement coincides with the patient's imminent death and continues through the actual death event and the period of time immediately thereafter.
7. Explain that the need to repeatedly verbalize feelings is a normal part of grieving.

EOL-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the patient's specific disease process, hospice care, end of life issues, advanced directives, support groups or community resources as appropriate.

STANDARDS:

1. Provide patient/family with written patient information literature.
2. Discuss the content of the patient information literature with the patient/family.

EOL-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the physiological, emotional and spiritual lifestyle adjustments necessary to cope with their terminal illness. They will understand that the plan of care will be based on the patient's wishes and the family's needs to enhance comfort and improve the quality of the patient's life.

STANDARDS:

1. Explain that the patient/family's values and beliefs will be respected and that the patient/family will be included in the decision making process.
2. Explain the need to remain active and the need to participate in familial, social, traditional, cultural and religious/spiritual activities and interactions when possible.
3. Explain the requirement for increased rest and sleep.
4. Assist with appropriate grieving strategies based on the provider's assessment of the patient/family's level of acceptance.
5. Refer to Social Services, Mental Health, Physical Therapy, Occupational Therapy, hospice, and/or community resources as appropriate.
6. Review lifestyle areas that may require adaptations (i.e., diet, physical activity, sexual activity, bladder/bowel habits, role changes, communication skills and interpersonal relationships). Discuss lifestyle changes in relation to his/her disease progression.
7. Inform the patient/family of local resources to accommodate their need for privacy and family gatherings if available.
8. Explain the importance of safety and infection control as applicable.

EOL-LW LIVING WILL

OUTCOME: The patient/family will understand the process of making a living will and its role in maintaining a sense of control in the patient's medical care and decisions.

STANDARDS:

1. Review the option of Advanced Directives/ Living Will with the patient and his/her family. Explain treatment options and answer questions in a manner the patient/family will understand.
2. Refer to appropriate services to assist the patient in making a living will, i.e., Social Services, Clergy, Lawyer.
3. Discuss giving designated persons access to the patient's complete health record and care management, including all necessary legal documents.

EOL-M MEDICATION

OUTCOME: The patient/family will understand the role of medication in control of pain and other discomforts. The patient/family will verbally summarize the medication regimen and the importance of full participation with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications.
2. Discuss the medication treatment plan.
3. Explain that pain, nausea and other discomforts can usually be controlled with medication. Discuss the use of adjunctive medication, if indicated, to control analgesic side effects, i.e., anti-emetics, laxatives, antacids.
4. Emphasize the importance of the patient/family's active participation with the provider in treatment decisions.
5. Explain that acute, severe or breakthrough pain should be immediately reported to the provider.
6. Discuss patient/family concerns about addiction. Explain that addiction is not an issue for terminally ill patients.
7. Discuss the importance of full participation with the medication regimen in order to assure optimal comfort levels. For example, round-the-clock dosing of pain medication is more effective in the treatment of chronic pain than medications that are taken after the pain recurs.
8. Explain that insomnia is often a significant problem for end of life patients. Emphasize the importance of developing a plan with the provider to address this issue as appropriate.
9. Explain that spiritual pain is a reality and cannot be controlled with medications.
10. Explain that excess sedation and euphoria are not goals of palliative pharmacologic therapy.
11. Explain that to some extent, pain may counteract the sedative and respiratory depressant effects of opiates.

EOL-N NUTRITION

OUTCOME: The patient/family will understand the importance of a nutritionally balanced diet in the treatment of their disease and the support of the terminal patient.

STANDARDS:

1. Assess the patient's current nutritional habits. Review how these habits might be improved.
2. Emphasize the necessary component - WATER - in a healthy diet.
3. Explain that constipation is a common side-effect of opiates. Dietary measures such as increased water, increased fiber, increased fruit juices and decreased intake of milk products may be helpful. Other control measures should be discussed with the provider prior to initiation.
4. Encourage ingestion of small, frequent meals and/or snacks.
5. Emphasize the importance of mouth care as appropriate.
6. If a specific nutrition plan is prescribed discuss this with the patient/family.
7. Discuss that failure to thrive may be a sign of impending death and may be seen in spite of adequate nutritional intake.

EOL-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process/aging process of this particular diagnosis and patient; and may be multifaceted. **Refer to PM.**
2. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain.
3. Explain non-pharmacologic measures that may be helpful with pain control.

EOL-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand that grief reactions are common at the end of life and that depression may be seen.

STANDARDS:

1. Discuss symptoms of grief reaction, i.e., vigilance, trouble concentrating, hyperattentiveness, insomnia, distractibility.
2. Explain that the patient/family may need additional support, sympathy, time, attention, compassion and communication.
3. Explain that if anti-depressant drugs are prescribed by the provider, full participation with the treatment regimen is important to maximize effectiveness of the treatment.
4. Refer to community resources as appropriate, i.e., bio-feedback, yoga, Healing Touch, Herbal Medicine, laughter, humor, Traditional Healer, guided imagery, massage, acupuncture, acupressure.
5. Explain that many mechanisms for dealing with grief and depression are available, i.e., support groups, individual therapy, family counseling, spiritual counseling. Refer as appropriate.

EOL-SM STRESS MANAGEMENT

OUTCOMES: The patient/family member will understand the role of stress management in end of life situations.

STANDARDS:

1. Explain that uncontrolled stress can contribute to a faster decline in physical health and cause further emotional distress for the patient, as well as contribute to physical illness, emotional distress, and early mortality of the caregiver.
2. Explain that effective stress management may help to improve the patient's outlook, as well as the health and well-being of both the patient, caregiver and family members.
3. Emphasize the importance of seeking professional help as needed to reduce stress.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality of both the caregiver and the patient.
5. Discuss various stress management strategies which may maintain or improve quality of life. Examples for patient, caregiver and family members may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. practicing meditation
    i. self-hypnosis
    j. using positive imagery
    k. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    l. spiritual or cultural activities
6. Provide referrals as appropriate.

EOL-TX TREATMENT

OUTCOME: The patient/family will understand the difference between palliative and curative treatments; and understand that the focus of the treatment plan will be on the quality of life rather than quantity of life.

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of a treatment plan.
2. Explain what signs/symptoms should prompt an immediate call to the provider.
3. Explain the difference between palliative and curative treatments.
4. Explain that end of life treatments will typically not prolong the patient's life but are meant to improve the quality of life by increasing patient comfort.

F

F—Fever

F-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and important complications of fever.

STANDARDS:

1. Explain that most fevers are harmless and are the body's natural response to infection and that fever may even be helpful in fighting infection.
2. Explain that fevers below 107˚F (41.6˚C) do not typically cause any type of permanent damage. Explain that the brain's thermostat keeps untreated fever below this level.
3. Discuss that only about 5% of children who develop fever may have a brief seizure associated with the fever. Explain that this type of seizure is generally harmless and will usually go away as the child gets older. Seizures with fever in adults are not febrile seizures and may require further investigation.
4. Discuss the potentially fatal complications of fever in a child under 2 months of age. **Refer to NF.**

F-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the role of fever in illness.

STANDARDS:

1. Discuss that fever is a body temperature that is above normal. Discuss the parameters used by your institution to define significant fever, i.e., rectal or oral temperature >101˚F or >38˚C.
2. Discuss that fever is a symptom, not a disease.
3. Discuss that fever is the body's natural response to infection.
4. Explain that fever helps fight infections by turning on the body's immune system and impeding the spread of the infection.
5. Explain that the height of the fever does not necessarily correspond to the seriousness of the illness. Explain that a better indicator of seriousness of illness is how sick the child or adult acts.
6. Discuss that most fevers are caused by viral illnesses, some are caused by bacterial illnesses. Explain that viral illnesses do not respond to antibiotic therapy.

F-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.

F-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up for fever.

STANDARDS:

1. Explain the importance of returning to the clinic or emergency room immediately if the patient should become more ill, become lethargic, look very sick or develop a purple rash.
2. Discuss that if the patient does not seem to be getting better after a few days of treatment the patient may need to be re-evaluated.
3. Discuss the need to return to the clinic or emergency room for fever that will not come down with antipyretics (i.e., acetaminophen, ibuprofen) or is over 105° F (40.5˚C).
4. Discuss the potentially fatal complications of fever in a child under 2 months of age. Explain that any child with a fever who is under 2 months of age should be seen by a physician immediately. **Refer to NF**.

F-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home care techniques for responding to fever, as appropriate to this patient.

STANDARDS:

1. Explain that fever causes excess loss of body fluids because of sweating, increased heart rate and increased respiratory rate. Discuss the importance of extra fluids to replace this excess body fluid loss.
2. Explain that clothing should be kept to a minimum as most body heat is lost through the skin. Bundling will cause higher fever.
3. Discuss that sponging is not usually necessary to reduce fever.
    a. Explain that sponging without giving acetaminophen or ibuprofen may cause shivering and this may actually increase the fever.
    b. Instruct that if shivering occurs during sponging that the sponging should be discontinued to allow the fever reducing agent to work.
    c. Discuss that if sponging is done, only lukewarm water should be used. Since sponging works to lower the temperature by evaporation of water from the skin's surface, sponging is more effective than immersion.
    d. Explain that only water should be used for sponging.
4. Explain that the use of rubbing alcohol for sponging may cause the fumes to be breathed in and could cause coma.

F-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about fever.

STANDARDS:

1. Provide the patient/family with written patient information literature on fever.
2. Discuss the content of the patient information literature with the patient/family.
3. Explain the need for follow-up if the fever lasts for more than 3 days.

F-M MEDICATIONS

OUTCOME: The patient/family will understand the use of antipyretics in the control of fever.

STANDARDS:

1. Emphasize that aspirin (even baby aspirin) should NEVER be used to control fever in children under the age of 13 except under the direction of a physician.
2. Discuss the appropriate dose of acetaminophen for this patient. Discuss that acetaminophen may be given every 4-6 hours for the control of fever.
3. Discuss the appropriate dose of ibuprofen for this patient. Discuss that ibuprofen may be given every 6-8 hours for the control of fever.
4. As appropriate, discuss dosing of other fever reducing agents that may be used for this patient.
5. Discuss avoidance of combination products (i.e., antipyretics combined with decongestants) unless directed to do so by a provider.
6. Discuss the method for combining acetaminophen and ibuprofen for the control of fever if appropriate. (Alternate the two medicines, i.e., acetaminophen every 8 hours and ibuprofen every 8 hours, giving one then the other at 4 hour intervals.)

F-TE TESTS

OUTCOME: The patient/family will understand that testing is necessary to determine the etiology of the fever. They will also have an understanding of the potential adverse outcomes of the tests to be performed or the risks of not performing the recommended tests.

STANDARDS:

1. Discuss with the patient/family the test(s) to be performed. Discuss the procedure for performing the test(s) in terms that can be understood by the patient /family.
2. Explain the benefit of the test as well as the risk(s) involved in performing the test(s). Explain the risk(s) associated with not performing the recommended test(s).
3. Explain that obtaining the results of some tests routinely performed to determine the etiology of fever (cultures of various body fluids) can take several days.

FF—Formula Feeding

FF-FS FORMULA FEEDING SKILLS

OUTCOMES: The parents/family will understand the skills for successful formula feeding during a baby's first year.

STANDARDS:

1. Explain the importance of selecting an age appropriate nipple that is comfortable to baby's mouth to feed formula at a rate that the baby can manage.
2. Emphasize that the infant should be held at a proper angle during feeding and that bottles should never be propped.
3. Emphasize that choking may result from the baby being left unattended with a bottle propped.
4. Explain that choice between plastic and glass bottles is up to parents. Glass is easy to clean dries quickly, and holds temperature better than plastic.
5. Explain the types of formulas available that are best suitable for baby's needs. Most infants require iron fortified formulas for brain growth.
6. Explain that some manufactures say their formula is "closer to breastmilk." This only means that the protein, fat, and other ingredients are more like that in breastmilk, not that the other formulas have all the unique nutritional and beneficial qualities of breastmilk.
7. Explain that fussing, spitting up, pulling off the nipple, or baby not wanting to eat during or after feeding may not necessarily be a problem with formula intolerance.
8. Explain that frequent stomachaches or vomiting, cough, runny nose and wheezing, skin itching and rash are examples of formula intolerance or allergy.
9. Explain that all commercial infant formulas are sufficient for the first year of life and that a change of formula is not necessary.
10. Explain that a formula fed baby does not need a fluoride supplement unless the water used to prepare formula has less than 0.3 ppm of fluoride.

FF-I INFORMATION

OUTCOME: The parents/family will have a basic understanding of the characteristics associated with formula feeding.

STANDARDS:

1. Explain that breastmilk has some characteristics that cannot be duplicated by even the most sophisticated formula; however, formula feeding is a good substitute.
2. Explain the higher risk of childhood obesity and type 2 diabetes for babies that are not breastfed.
3. Explain the higher risk of diarrhea, ear infections, constipation, dental carries, and lung infections for babies that are not breastfed.
4. Explain the higher risk of post partum hemorrhage and breast/ovarian cancer for mothers that do not breast-feed.
5. Explain that an infant under 1 year of age may be harmed by feeding goat's or cow's milk.
6. Emphasize that nothing should be fed to an infant from a bottle except breastmilk or formula unless advised by a health care professional.
7. Explain resources, such as WIC, for formula feeding and types.

FF-L PATIENT INFORMATION LITERATURE

OUTCOME: The parent(s) and family will receive written information about formula feeding.

STANDARDS:

1. Provide the parent(s) and family with written information about formula feeding.
2. Discuss the content of the patient information literature with the parent(s) and family.

FF-ME MATERNAL ENGORGEMENT

OUTCOME: Parents/family will understand how to successfully transition through breast engorgement in postpartum period.

STANDARDS:

1. Explain that stimulation to breast, such as pumping or suckling will prolong engorgement beyond 48 hours.
2. Encourage mother to use breast binder or snug bra until swelling goes away.
3. Explain signs of breast infection, such as sudden fever/malaise and need for pursuing medical evaluation.
4. Explain current treatments for engorgement.

FF-NJ NEONATAL JAUNDICE

OBJECTIVE: The family will understand the importance of monitoring for jaundice and the complications of unrecognized jaundice.

STANDARDS:

1. Explain that jaundice is the yellow color seen in the skin of many newborns which is caused by build up of bilirubin in the blood.
2. Explain that everyone's blood contains bilirubin, which is removed by the liver and that before birth, the mother's liver does this for the baby. Explain that many babies develop jaundice in the first few days after birth because it takes a few days for the baby's liver to get better at removing bilirubin.
3. Explain that the yellow skin color caused by bilirubin usually appears first in the face then moves to the chest, abdomen, arms and legs as the bilirubin level increases. Explain that the whites of the eyes may also be yellow.
4. Explain that mild jaundice is harmless but high levels of bilirubin may cause brain damage.
5. Explain that this brain damage can be prevented by treatment of the jaundice before the bilirubin level gets too high. Discuss that treatment options may include medical phototherapy or exchange transfusion.
6. Emphasize that parents should watch closely for jaundice and seek medical attention if jaundice is noticed.
7. Explain that medical personnel can check the level of bilirubin in the blood by blood tests or occasionally by a skin test.
8. Explain that all bilirubin levels must be interpreted in light of the infant's age and that term infants and older infants can tolerate higher levels of bilirubin than preterm infants and younger infants.
9. Explain that jaundice is more common in breastfed infants especially when the infant is not nursing well. Encourage nursing the infant a minimum of 8-12 times a day for the first week of life to increase milk production and keep bilirubin levels down. Emphasize that breastmilk is the ideal food for infants.

FF-S SAFETY OUTCOMES

OUTCOME: Parents/family will understand of preparing and storing formula.

STANDARDS:

1. Emphasize that the infant should be held at a proper angle during feeding and that bottles should never be propped.
2. Emphasize that choking may result from the baby being left unattended with a bottle propped.
3. Explain that bottle liners must be discarded after each use.
4. Explain that babies during the first three months of age have low resistance to bacteria and boiling water for 5 minutes before mixing formula may be necessary if the purity of water is in question. This also applies to purified or distilled water. **Refer to PB-TX**.
5. Explain that boiling bottles and nipples for 5 minutes, washing with hot, soapy water, and/or using a dishwasher before use is also recommended.
6. Explain that following manufactures instructions for mixing formula is extremely important and also using recommended measuring cups and spoons.
7. Explain that bottles should be prepared one at a time or in small batches, label, cover, refrigerate, and use within 48 hours. Discard any unused formula after each feeding and then wash the bottle immediately.
8. Explain that warming a formula bottle is best done under running tap water. Do not use a microwave oven to warm formula bottles.
9. Explain that bottle nipples should be discarded when they are old, soft, cracked, or discolored.

FF-SF INTRODUCTION TO SOLID FOODS

OUTCOME: The parent/family will understand the appropriate ages to introduce various solid foods. (teach any or all of the following as appropriate to this infant/family)

STANDARDS:

1. Explain that infants should not routinely be fed foods other than breastmilk or formula prior to 4 months of age except under the advice of a healthcare provider.
2. Emphasize that, for some time after the introduction of solid foods, breastmilk/formula will still be the infant's primary source of nutrition.
3. Emphasize that foods should never be given from a bottle or infant feeder and must always be fed from a spoon.
4. Explain that infants may be fed cereal mixed with breastmilk or formula not sooner than 4 months of age. Rice cereal is generally the preferred first solid food. It is normal for an infant to take very small amounts of solid foods for several months. Discard any uneaten food after each meal.
5. Emphasize the need to wait 3-5 days between the addition of new foods to watch for adverse events from the foods.
6. Explain that pureed/or finely mashed vegetables and fruits should be started no earlier than 6 months of age.
7. Explain that some foods such as peanut butter, chocolate, eggs, strawberries, cow or goat milk and citrus should not be fed until the infant is one year of age due to the highly allergenic nature of these foods. Explain that honey and syrups may contain botulism toxin and should not be fed before one year of age.
8. Explain that infants 14-16 moths of age will have a decreased appetite and will become more picky eaters.
9. Emphasize that some foods are easy to choke on and should be avoided until 4 years of age, i.e., nuts, hard candies, gum, carrot sticks, meat on a bone, grapes, popcorn, hot dogs, unpeeled apples, slices of orange.
10. Discuss the importance of offering foods at the appropriate ages but do not insist that infants eat foods when they are not hungry:
    a. Baby knows how much to eat
    b. It is important to go along with the baby when they feel they have finished eating
    c. Some days babies eat a lot other days not as much
    d. No two babies eat the same
11. Explain how to assess readiness, an infant:
    a. who exhibits tongue thrusting is not ready to eat solids.

b. will give you cues to readiness when they open their mouths when they see something coming

c. will close lips over a spoon

d. will keep food in their mouth instead of spitting it out

e. will sit up alone without support

12. Explain that the body of knowledge regarding infant feedings has changed dramatically and advice from family/friends may no longer be appropriate; talk to your healthcare provider.

FRST—Frostbite

FRST-C COMPLICATIONS

OUTCOME: The patient and/or family will understand the consequences of frostbite; and the complications associated with frostbite.

STANDARDS:

1. Explain that the severity of frostbite is associated with how deep the freeze is. No tissue is safe. This can involve the skin layers as well as the fat, muscle, blood vessels, lymphatics, nerves and even the bones.
2. Discuss that frostbite is just like receiving a burn; and is categorized based upon the extent of the tissue injury.
    a. First Degree: is a partial freeze of the skin. Clinical Appearance: Redness, swelling, possible peeling of skin about a week later. Symptoms: Periodic burning, stinging, aching, throbbing; excessive sweating in the area.
    b. Second Degree: All layers of the skin have frozen. Clinical Appearance: Redness, significant swelling, blisters, black scabs, Symptoms: Numbness, heaviness of the affected area.
    c. Third Degree: Skin and subcutaneous tissues are completely frozen. Clinical Appearance: Purplish blisters (blood-filled), dusky blue skin discoloration, death of the skin. Symptoms: Loss of sensation, area feels like “wood”. Later on, the area has significant burning and throbbing.
    d. Fourth Degree: Complete involvement of skin, fat, muscle, bone. Clinical Appearance: Minimal swelling. The area is initially quite red, then becomes black. Symptoms: Occasional joint pain.
3. Emphasize the importance to avoid thawing and then refreezing the injury. This is very dangerous and can cause serious sequella.

FRST-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

FRST-DP DISEASE PROCESS

OUTCOME: The patient and/or family will understand how frostbite occurs the signs and symptoms of frostbite, and risk factors associated with frostbite.

STANDARDS:

1. Explain that frostbite, simply defined, is the freezing of the skin and/or the bodily tissues under the skin.
2. Discuss signs and symptoms of frostbite with the patient/family:
    a. Mild frostbite (frostnip) affects the outer skin layers and appears as a blanching or whitening of the skin.
    b. Severe frostbite: the skin will appear waxy-looking with a white, grayish-yellow or grayish-blue color.
    c. Affected body parts will have no feeling (numbness) and blisters may be present.
    d. The tissue will feel frozen or "wooden".
    e. Other symptoms include swelling, itching, burning and deep pain as the area is warmed.
3. Discuss the pathophysiology of frostbite: the fluids in the body tissues and cellular spaces freeze and crystallize. This can cause damage to the blood vessels and result in blood clotting and lack of oxygen to the affected area.
4. Review with patient/family predisposing conditions to frostbite:
    a. exposure of the body to cold
    b. length of time a person is exposed to the cold
    c. temperature outside
    d. wind-chill factor
    e. humidity in the air
    f. wetness of clothing and shoes
    g. ingestion of alcohol and other drug
    h. high altitudes
5. Explain that frostbite can occur in a matter of minutes.
6. Discuss with patient/family that the most common parts of the body affected by frostbite include the hands, feet, ears, nose and face.
7. Review with patient/family the medical conditions that make some at greater risk for frostbite:
    a. the elderly and young
    b. persons with circulation problems
    c. history of previous cold injuries
    d. ingestion of particular drugs, i.e., alcohol, nicotine and beta-blockers
    e. persons from southern/tropical climates exposed to cold weather conditions.

FRST-FU FOLLOW-UP

OUTCOME: The patient and/or family will understand the seriousness of frostbite and the importance of follow up care.

STANDARDS:

1. Discuss the importance of follow up appointments after frostbite to determine if there is any permanent or ongoing damage.
2. Discuss the importance of keeping follow up appointments.
3. Discuss the procedures for obtaining follow up appointments.

FRST-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient and/or family will receive written information about frostbite, and important preventive measures.

STANDARDS:

1. Provide patient/family with written information on frostbite and prevention of frostbite.
2. Discuss the content of frostbite written information with the patient/family.

FRST-M MEDICATIONS

OUTCOME: The patient/family will understand the use of medications to manage frostbite.

STANDARDS:

1. Explain to patient/family that the blistered areas may require topical medications applied during dressing changes as prescribed by provider.
2. Discuss appropriate medications available for acute and chronic pain.
3. Advise patient/family that a tetanus vaccination is necessary if not received in last 5-10 years.
4. Discuss the common and important side effects and drug interactions of medications prescribed.

FRST-N NUTRITION

OUTCOME: The patient/family will understand the nutritional problems associated with frostbite.

STANDARDS:

1. Discuss that based on severity of the injury the need for replenishment of calories, fluids, protein, nitrogen and other nutrients may be essential.
2. Refer to a registered dietician as appropriate.

FRST-P PREVENTION

OUTCOME: The patient/family will understand ways to prevent frostbite.

STANDARDS:

1. Discuss with the patient/family that the majority of frostbite cases are preventable, and that it is easier to prevent frostbite than to treat it.
2. Emphasize the importance of keeping clothing/socks dry. Wet clothing predisposes to frostbite.
3. Explain that it is important to minimize wind exposure. Wind proof clothing can be helpful. High winds increase heat loss from the body.
4. Discuss that it is important to wear loose, layered clothing (i.e., hat, gloves, loosely fitting layered clothing). Constrictive clothing increases the likelihood of frostbite as does immobilization and dependency of the extremities. Proper clothing for winter weather insulates from the cold, lets perspiration evaporate and provides protection against wind, rain and snow. Wear several layers of light, loose clothing that will trap air, yet provide adequate ventilation. This is better protection than one bulky or heavy covering.
5. Discuss the importance to stocking the vehicle appropriately for winter travel (i.e., blankets, gloves, hats).
6. Discuss that when in frostbite-causing conditions, dressing appropriately, staying near adequate shelter and remaining physically active can significantly reduce the risk of suffering from frostbite.
7. Discuss the importance of avoiding alcohol, and other drugs while participating in outdoor activities.
8. Review the sensations associated with overexposure to cold, i.e., sensations of intermittent stinging, burning , throbbing and aching are all early signs of frostbite. Get indoors.
9. Discuss with patient/family the medical conditions that make some at greater risk for frostbite:
    a. the elderly and young
    b. persons with circulation problems
    c. history of previous cold injuries
    d. ingestion of particular drugs, i.e., alcohol, nicotine and beta-blockers
    e. persons from southern/tropical climates exposed to cold weather conditions.

FRST-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand how to manage the pain associated with the acute and chronic tissue damage caused from frostbite.

STANDARDS:

1. Discuss that there has been some evidence that aloe vera in a 70% concentration when applied topically may be helpful in pain management.
2. Discuss appropriate pain management plan with patient/family.

FRST-TX TREATMENT

OUTCOME: The patient and/or family will understand the management and treatment of frostbite.

STANDARDS:

1. Discuss the goal of treatment with the patient; prevention of further exposure to affected area(s), and management and prevention of complications.
2. Emphasize the need to have frostbite injuries rewarmed under medical supervision.
3. Explain that the patient needs to get to a warm place where he/she can stay warm after thawing. Refreezing can cause more severe tissue damage.
4. Review proper thawing process:
    a. Use warm-to-the touch water 100˚ F (38˚ C.) For 30-45 minutes until a good color (flush) has returned to the entire area. Emphasize that this process may be painful, especially the final few minutes.
    b. Leave the blisters intact. Cover with a sterile or clean covering if protection is needed to prevent rupturing of blisters.
    c. Keep the affected part(s) as clean as possible to reduce the risk of infection.
    d. Keep the affected area elevated above the level of the heart.
5. Emphasize the importance of having a current tetanus booster (within5-10 years).
6. Review treatment modalities that are not deemed appropriate methods to treat frostbite:
    a. Don’t use dry heat (sunlamp, radiator, heating pad) to thaw the injured area.
    b. Don’t thaw the injury in melted ice.
    c. Don’t rub the area with snow.
    d. Don’t use alcohol, nicotine or other drugs that may affect blood flow.

FRST-WC WOUND CARE

OUTCOME: The patient/family will understand the necessity and procedure for proper wound care.

STANDARDS:

1. Explain the reasons to care appropriately for the wound, i.e., decreased infection rate, improved healing.
2. Explain the correct procedure for caring for this patient's wound.
3. Explain signs or symptoms that should prompt immediate follow-up, i.e., increasing redness, purulent discharge, fever, increased swelling/pain.
4. Detail the supplies necessary for the care of this wound (if any) and how/where they might be obtained.
5. Emphasize the importance of follow-up.
6. Demonstrate the necessary wound care techniques.

G

GB—Gallbladder

GB-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient will have a basic understanding of where the gallbladder is in the body and its function in digestion.

STANDARDS:

1. Discuss that the gallbladder is a small bag found under the liver.
2. Explain that the function of a normal gallbladder is to store bile, concentrate it by removing water and empty this concentrated bile into the intestine when fatty foods are eaten.
3. Explain that the gallbladder empties through the cystic duct into the common bile duct which then empties into the small intestine. Explain that the common bile duct also drains the liver and the pancreas.
4. Explain that the bile helps to digest the fat in the foods.

GB-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of untreated or progressed gallbladder disease. (Please choose from the following standards as they apply to this patient's specific disease process.)

STANDARDS:

1. Explain that if the amount of bile and other chemicals inside the gallbladder get out of balance gallstones can form. Most gallstones are cholesterol gallstones and form when too much cholesterol is secreted into the gallbladder from the liver.
2. Explain that gallstones usually don't cause a problem if they stay in the gallbladder. Approximately 80% of people with gallstones have no symptoms at all.
3. Explain that sometimes gallstones move into the ducts that drain the gallbladder and that this may lead to pain, infections, diseases of the liver, disease of the pancreas and may lead to gangrene or perforation of the gallbladder.
4. Empyema of the gallbladder (pus in the gallbladder) is a serious complication of acute cholecystitis and can result in death in about 25% of cases. Empyema is relatively rare, however, it does occur in about 2% of cases of acute cholecystitis.
5. Explain that patients with choledocholithiasis (stones in the common bile ducts) may get cholangitis (infection of the bile ducts). This is very serious and may be treated with antibiotics and may require surgery. Choledocholithiasis may also result in pancreatitis. **Refer to PC.**
6. Explain that risk of serious complications can be reduced by seeking prompt medical attention.

GB-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the causes and symptoms of his/her gallbladder disease. (Please choose from the following standards as they apply to this particular patient.)

STANDARDS:

1. Explain that gallstones (cholelithiasis) can cause problems when a gallstone gets lodged in either the cystic duct or the common bile duct. This can result in right upper quadrant abdominal pain, nausea, vomiting, heartburn and back pain.
2. Explain that gallstones in the common bile duct can also result in jaundice or pancreatitis. This condition is called choledocholithiasis.
3. Explain that biliary colic is a mild form of gallbladder disease and results in right upper quadrant abdominal pain several hours after eating a fatty meal. The pain is not relieved by changes in position, over-the-counter medications or passing gas. It will usually spontaneously resolve in 1-5 hours.
4. Explain that acute cholecystitis is similar to biliary colic but is more severe. It results from inflammation of the gallbladder. Infection is often present. The pain with cholecystitis is more severe and often patients complain of pain with breathing. This is a severe condition which can progress to perforation of the gallbladder or gangrene. Patients with acute cholesystitis should seek immediate medical attention.
5. Explain that chronic cholecystitis results from long term inflammation of the gallbladder with or without stones and results in scarring of the gallbladder. Patients with chronic cholecystitis will often have gas, nausea or abdominal discomfort after meals.
6. Explain that some drugs may induce gall bladder disease.
7. Explain that gallbladder disease is more common in the following groups of people:
    a. Women
    b. People over 40
    c. Women who have been pregnant (especially women with multiple pregnancies)
    d. People who are overweight
    e. People who eat large amounts of dairy products, animal fats and fried foods, i.e., high fat diet
    f. People who lose weight very rapidly
    g. People with a family history of gallbladder disease
    h. Native Americans (especially Pima Indians), Hispanics and people of Northern European descent
    i. People with sickle-cell anemia, cirrhosis, hypertriglyceridemia (especially with low HDL cholesterol),or diabetes.

GB-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of fully participating in the treatment regimen and make a plan for appropriate follow-up.

STANDARDS:

1. Discuss the individual's responsibility in the management of gallbladder disease.
2. Review the treatment plan with the patient, emphasizing the importance for follow-up care.
3. Discuss the procedure for obtaining follow-up appointments.

GB-L LITERATURE

OUTCOME: The patient/family will receive written information about gallbladder disease.

STANDARDS:

1. Provide the patient/family with written patient information literature on gallbladder disease.
2. Discuss the content of patient information literature with the patient/family.

GB-M MEDICATIONS

OUTCOME: The patient/family will understand the medications to be used in the management of gallbladder disease.

STANDARDS:

1. Explain as indicated that some medications may be used to dissolve small gallstones.
2. Explain the regimen to be implemented in pain control as indicated.
3. Explain the medications to be used in this patient including the dosage, timing, proper use and storage of the medication, important and common side-effects of the medication including drug-drug and drug-food interactions.

GB-N NUTRITION

OUTCOME: The patient/family will understand ways diet relates to gallbladder disease.

STANDARDS:

1. Explain that a diet that is high in fat and simple sugars can contribute to the formation of gallstones.
2. Explain that rapid weight loss should be avoided as it may contribute to formation of gallstones. Encourage overweight persons to undertake a rational approach to weight loss that includes exercise and moderate dietary limitation under the consultation of a physician.

GB-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of gallbladder disease.

STANDARDS:

1. Explain that maintaining a normal body weight and avoiding fasts are keys to reducing the risk of gallstones.
2. Explain that a low fat diet will help prevent gallbladder disease.
3. Explain that regular vigorous exercise reduces the risk of gallbladder disease. Exercises that seem most helpful are brisk walking, jogging, and racquet sports.

GB-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management in gallbladder disease is specific to the disease process of this particular patient and may be multifaceted.
2. Explain that often antispasmodics may be helpful.
3. Explain that short term use of narcotics may be helpful in pain management.
4. Explain that other medications may be helpful to control the symptoms of nausea and vomiting.
5. Explain that administration of fluids may help with pain relief and resolution of symptoms.
6. **Refer to PM.**

GB-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure(s) as well as risks, benefits and alternatives to the proposed procedure(s). **Refer to SPE.**

STANDARDS:

1. Explain the specific procedure to be performed including the risks and benefits both of doing the procedure and adverse events which might result from refusal of the procedure.
2. Discuss alternatives to the proposed procedure including expectant management, as appropriate.

GB-TE TESTS

OUTCOME: The patient/family will understand the proposed test(s) as well as risks, benefits and alternatives to the proposed test(s).

STANDARDS:

1. Explain the test to be performed including the potential benefit to the patient and any adverse effects of the test or adverse effects which might result from refusal of the test.
2. Explain the testing process to help the patient understand what he/she might experience during the test.
3. Explain any preparation the patient may need to do for the proposed test, i.e., NPO status.

GE—Gastroenteritis

GE-C COMPLICATIONS

OUTCOME: The patient/family will understand the possible complications of gastroenteritis and which patients are at high risk for complications.

STANDARDS:

1. Discuss the common or serious complications of gastroenteritis, such as:
   a. dehydration
   b. electrolyte imbalance
   c. need for hospitalization.
2. Explain that people with concurrent or chronic illness, the elderly, the very young, or people who have prolonged episodes of gastroenteritis are at higher risk for complications.

GE-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

GE-DP DISEASE PROCESS

OUTCOME: The patient will understand the causes and symptoms of gastroenteritis.

STANDARDS:

1. Explain that gastroenteritis is usually caused by a viral infection and will go away on its own.
2. Review the signs and symptoms of gastroenteritis such as:
   a. colicky abdominal pain
   b. fever which may be low grade or higher
   c. diarrhea
   d. nausea and/or vomiting.
3. Discuss the potential for dehydration and signs of dehydration:
   a. dry sticky mouth
   b. no tears when crying
   c. no urine output for 8 hours or more
   d. sunken fontanelle (in an infant)
   e. sunken appearing eyes
   f. others as appropriate.
4. Explain the need to seek immediate medical care if dehydration is suspected.

GE-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of fully participating in treatment regimen and make a plan for appropriate follow-up.

STANDARDS:

1. Discuss the individual's responsibility in the management of gastroenteritis.
2. Review the treatment plan with the patient, emphasizing the importance of checking for signs of dehydration.
3. Discuss the procedure for obtaining follow-up appointments as appropriate.

GE-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of gastroenteritis and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer future infections, fewer emergency room visits, fewer hospitalizations and fewer complications, as well as a healthier life.
3. Explain the relationship between hygiene and infection control principles. Emphasize importance of hand washing.

GE-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about gastroenteritis.

STANDARDS:

1. Provide the patient/family with written information about gastroenteritis.
2. Discuss the content of patient information literature with the patient/family.

GE-M MEDICATIONS

OUTCOME: The patient /family will understand the limited role medications play in the management of gastroenteritis.

STANDARDS:

1. Explain that in most cases of gastroenteritis no medication is needed.
2. If medication is prescribed for nausea relief or diarrhea control, provide a brief description of how the medication works, what the common or problematic side-effects.
3. Explain that many medications prescribed for nausea or diarrhea may cause drowsiness and the patient should avoid activities such as driving or operating heavy machinery while using these medications.
4. Explain the importance of proper hydration even in the face of drowsiness.

GE-N NUTRITION

OUTCOME: The patient will understand ways to treat gastroenteritis by nutritional therapy.

STANDARDS:

1. Explain that in gastroenteritis the gastrointestinal tract is not working properly.
2. Explain that gastrointestinal rest is essential to quick recovery from gastroenteritis.
3. Explain that water and many other clear liquids are rapidly absorbed across the stomach wall and do not require that the gastrointestinal tract be working properly. (Oral electrolyte solutions are excellent clear fluids for all who will take them.)
4. Discourage the use of juices as many of them will make the diarrhea worse.
5. Discourage the use of caffeinated beverages as they are dehydrating.
6. Explain that clear liquids taken in small amounts and frequently will often result in resolution of the vomiting, i.e., 1 teaspoonful to 1 tablespoonful every 5-10 minutes.
7. Explain that it is usually appropriate to go to a high starch/low fat diet gradually.

GE-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Explain non-pharmacologic measures that may be helpful with pain control.

GE-TE TESTS

OUTCOME: The patient /family will understand the conditions under which testing is necessary and the specific test(s) to be preformed, technique for collecting samples and the expected benefit of testing and any associated risks. The patient/family will also understand alternatives to testing and the potential or risks associated with the alternatives, i.e., risk of non-treatment.

STANDARDS:

1. Explain that tests may be necessary for prolonged gastroenteritis or gastroenteritis accompanied by diarrhea with blood or mucus. Discuss the procedure for collecting the sample, the benefit expected and any associated risks.
2. Explain the alternatives to the proposed test(s) and the risk/benefits ratio of the testing and alternatives including the risk of non-treatment.

GE-TX TREATMENT

OUTCOME: The patient/family will understand the treatment plan for gastroenteritis.

STANDARDS:

1. Explain that the major treatment for viral gastroenteritis is dietary modification.
2. Explain that if the gastroenteritis is caused by a bacterium, antibiotics may be prescribed.
3. Explain that if the patient fails attempts at oral rehydration, I.V. rehydration is frequently necessary.

GER—Gastroesophageal Reflux Disease

GER-DP DISEASE PROCESS

OUTCOME: The patient will understand the anatomy and pathophysiology of gastroesophageal reflux disease.

STANDARDS:

1. Explain the anatomy and physiology of the esophagus and stomach.
2. Explain the process of acid reflux into the esophagus.
3. Explain how and why stomach acid reflux into the esophagus causes pain and disease.
4. Explain long-term complications of untreated GERD including carcinoma of the esophagus.

GER-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

GER-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about gastroesophageal reflux disease.

STANDARDS:

1. Provide the patient/family with written patient information literature on gastroesophageal reflux disease.
2. Discuss the content of the patient information literature with the patient/family.

GER-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient and/or family will understand how to control GERD through lifestyle adaptation.

STANDARDS:

1. Emphasize the importance of tobacco cessation and decreased alcohol consumption.
2. Identify obesity as a major exacerbating factor in GERD. Discuss the importance of regular exercise and its role in obtaining and maintaining desirable weight.
3. Identify foods that may aggravate GERD.
4. Review the effect of timing of meals, i.e., no large meals before bedtime, more frequent light meals instead of few large meals.
5. Discuss physical control measures such as elevating the head of the bed.

GER-M MEDICATIONS

OUTCOMES: The patient/family will understand the medication, dosage and side effects that may occur. Patient/family will understand how the medication works to prevent the symptoms of GERD.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication..
2. Explain how the medication works to prevent the symptoms of GERD.
3. Explain that non-pharmacologic therapies in combination with medications will help reduce the symptoms of GERD.
4. Emphasize the importance of possible drug interactions with foods and over the counter medications.

GER-N NUTRITION

OUTCOME: The patient will understand the need for balanced nutrition and plan for the implementation of dietary modification as needed.

STANDARDS:

1. Review normal nutritional needs for optimal health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss nutritional modifications as related to Gastroesophageal Reflux Disease.
4. Emphasize the importance of fully participating in the prescribed nutritional plan.

GER-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Explain non-pharmacologic measures that may be helpful with pain control.

GER-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in gastroesophageal reflux disease.

STANDARDS:

1. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all of which can increase the risk of morbidity from gastroesophageal reflux disease.
2. Explain that effective stress management may help reduce the severity of gastroesophageal reflux disease, as well as help improve the health and well-being of the patient.
3. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
4. Provide referrals as appropriate.

GER-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Upper gastrointestinal barium studies.
2. Explain that the upper GI barium study is an x-ray to assess the degree and extent of the disease.
3. Explain that barium liquid will be swallowed and radiographs taken.
4. Discuss NPO status as indicated.
5. Discuss the test(s) for H. Pylori and how testing may assist in diagnosis and treatment.
6. Discuss as appropriate the procedure for EGD and the risks and benefits of performing this test. **Refer to SPE.**

GER-TX TREATMENT

OUTCOME: The patient and/or family will understand the medical and surgical treatments available for GERD.

STANDARDS:

1. Discuss the use, benefits, and common side effects of the patient's prescribed medications.
2. Discuss possible surgical interventions for GERD as appropriate.

GAD—Generalized Anxiety Disorder

GAD-C COMPLICATIONS

OUTCOME: The patient/family will understand some of the complications associated with generalized anxiety disorder.

STANDARDS:

1. Discuss that GAD can cause major disruptions in family and work relationships. Refer to counseling or behavioral health services as appropriate.
2. Discuss that GAD can cause many physical symptoms such as chest pain, dizziness, abdominal pain, headaches, jaw pain, palpitations, shortness of breath, bruxism, broken teeth, fatigue, sleep disruption and other physical symptoms. Generalized anxiety disorder is frequently misdiagnosed as cardiac or gastrointestinal disease.
3. Explain that untreated GAD may worsen and result in depression and/or suicide.

GAD-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

GAD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand some of the current information about cause and expected course of generalized anxiety disorder and will make a plan to obtain treatment, when appropriate.

STANDARDS:

1. Explain that GAD is a primary disorder in which the patient has a constant and severe sense of anxiety/fear which is not attributable to a specific stressor and is significant enough to interfere with work, home, or social functioning.
2. Explain that as of May, 2003, it is believed that GAD results from a dysfunction of the GABA neurotransmitter system in the brain. Discuss that GAD is a neurochemical/biological disorder and is not the result of a weak personality or inappropriate parenting.
3. Explain that symptoms of GAD may include difficulty sleeping, difficulty with concentration, unusual sense of fear in ordinary circumstances, stressed relationships, inability to work with others, unusual number of physical complaints for which a source cannot be found.
4. Explain that because the symptoms of GAD are numerous and non-specific, the diagnosis can only be made by a trained healthcare professional. Explain that because GAD has a tendency to run in families, the health care professional will likely request information about other family members.
5. Explain that generalized anxiety disorder is typically a chronic disease which is often progressive and may be associated with other mental/emotional disorders. (For example: agoraphobia, panic disorder, and/or depression.)
6. Explain that the symptoms of GAD may get better or worse at different times; symptoms will often worsen when the patient is more stressed, but symptoms may not be related to outside stressors.
7. Explain that there is a tendency for GAD to worsen over time if it is not treated, but there are effective treatments available. **Refer to GAD-TX.**

GAD-EX EXERCISE

OUTCOME: The patient/family will understand the role of exercise in the treatment of generalized anxiety disorder.

STANDARDS:

1. Explain that it is believed that regular exercise favorably alters the chemistry of the brain by changing the levels of various neurotransmitter chemicals and by degrading ("burning up") stress hormones.
2. Explain that many physicians believe that exercise can be an important part of the treatment of GAD and other emotional disorders and that the patient's physician or other provider may prescribe exercise. As appropriate, encourage the patient to ask his/her physician or provider about starting an exercise program.
3. Explain that the optimal level of exercise may vary from patient-to-patient, but that 30 minutes of aerobic exercise (i.e., fast walking, bicycling, running, swimming laps) daily is usually enough to result in improvement in GAD symptoms.
4. Explain that other forms of exercise (i.e., weight-lifting, sit-ups) may very well be helpful, but have not been studied as well as aerobic exercise. Encourage the patient to engage in whatever form of exercise he/she is able and willing to do. This may include increasing daily activities, i.e., gardening, house cleaning, dancing.
5. Explain that most people should be evaluated by a physician or other provider before starting an exercise program. Refer to physician or provider as appropriate. Refer to community-based exercise program(s) as appropriate.
6. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
7. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
8. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
9. Discuss medical clearance issues for physical activity.

GAD-M MEDICATION

OUTCOME: The patient/family will understand the patient's medication regimen and some common or important side effects of medication as well as the possible risks of not using medication as prescribed.

STANDARDS:

1. Explain that medication is often required to improve the GAD patient's level of functioning at home, at work, and in social situations.
2. Explain that because GAD often occurs in conjunction with other emotional disorders, more than one medication may be necessary.
3. Explain (when appropriate, according to the medication prescribed) that some of the medications for GAD have some potential to cause addiction when they are not used as prescribed, but this is very unusual when medications are used properly. Emphasize the importance of adhering strictly to the prescribed regimen and not increasing or decreasing the medication without consulting the physician or provider who prescribed it.
4. Explain (when appropriate, according to the medication prescribed) that some of the medications for GAD are classified by the Drug Enforcement Administration as controlled substances and may be stolen by persons who wish to sell them or use them illicitly. Emphasize the importance of keeping strict control of medications, i.e., the patient may keep most of the medication in a locked cabinet and carry only a small amount in his/her pocket, purse. Refer the patient to the physician or provider who prescribed the medication regarding what to do if medication is lost or stolen.
5. Discuss common or important possible side effects which may be caused by the patient's medication. Discuss signs/symptoms of possible adverse medication effects and actions for the patient/family to take if they believe an adverse effect is occurring or has occurred.
6. Review possible drug/drug and drug/food interactions. Emphasize that it is dangerous to combine psychotropic medications with alcohol or street drugs, and that use of alcohol, street drugs or herbal supplements may make the prescribed medication ineffective.
7. Emphasize the importance of informing the provider of all medications, drugs, herbals and supplements that are used by the patient.
8. As appropriate, provide the patient/family with the phone numbers or other access information for the pharmacy, hospital emergency department, medication/drug hotline, and/or other available resources.

GAD-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in anxiety disorders.

STANDARDS:

1. Explain that uncontrolled stress is linked with the onset of major depression and contributes to more severe symptoms of anxiety.
2. Explain that uncontrolled stress can interfere with the treatment of anxiety disorders.
3. Explain that effective stress management may reduce the severity of symptoms the patient experiences, as well as help improve the health and well-being of the patient.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as inappropriate eating, all of which can increase the severity of the anxiety and increase the risk of depression and suicidal behaviors.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

GAD-TX TREATMENT

OUTCOME: The patient/family will understand what the treatment plan is for this patient, that the treatment plan will usually require some participation by other family and/or household members, and will make a plan to fully participate in the treatment plan.

STANDARDS:

1. Explain that treatment for GAD may vary according to the patient's life circumstances, severity of the condition, and resources available.
2. Explain that GAD usually can be treated successfully, but that the patient's active participation in the treatment plan is critical to a good outcome.
3. Explain that regular exercise will usually contribute significantly to improving the symptoms of GAD and in some cases will eliminate the need for medication. **Refer to GAD-EX.**
4. Explain that some form of counseling or psychotherapy will usually be prescribed initially and in some cases may be continued indefinitely.
5. Explain that medication may be prescribed; medication may be used chronically or intermittently according to circumstances. Explain that the decisions about timing and duration of medication will be made jointly by the physician or provider and the patient. **Refer to GAD-M.**
6. Explain that treatment for GAD will almost always require periodic follow-up with the physician or provider and often will require periodic follow-up with other health care professionals.

GIB—GI Bleed

GIB-C COMPLICATIONS

OUTCOME: The patient/family will understand the seriousness of gastrointestinal bleeding and will verbalize intent to obtain treatment if symptoms occur.

STANDARDS:

1. Explain that severe blood volume depletion and anemia can result from untreated gastrointestinal bleeding.
2. Explain that complications may be prevented with prompt treatment.
3. Discuss the symptoms of gastrointestinal bleeding, e.g. vomiting blood or coffee-ground emesis or black, tarry or bloody stools.

GIB-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

GIB-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the etiology and pathophysiology of their gastrointestinal disease.

STANDARDS:

1. Explain that gastrointestinal bleeding may have a variety of causes e.g. esophagitis, gastritis, peptic ulcers, esophageal varices, Crohn's disease, polyps, ulcerative colitis, diverticulosis or cancer.
2. Explain that the bleeding may present itself in a variety of ways, depending on the source and severity of the bleeding.
3. Explain that massive bleeding may result in weakness, dizziness, faintness, shortness of breath, crampy abdominal pain, diarrhea, or death.

GIB-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment, as appropriate.
3. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
4. For inpatients, explain that the various alarms are to alert the medical personnel of the patient’s status and/or the function of the equipment.
5. Emphasize the importance of not tampering with any medical device.

GIB –FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up, care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

GIB –L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the disease process involved with the gastrointestinal bleeding.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding the disease process involved with the gastrointestinal bleeding.
2. Discuss the content of the patient information literature with the patient/family.

GIB -M MEDICATIONS

OUTCOME: The patient will verbally summarize the prescribed medication regimen and the importance of full participation .

STANDARDS:

1. Review the proper use, benefits and common side effects of prescribed medications.
2. Discuss the use of antacids and medications to decrease acid production. Stress that absence of symptoms does not mean that the medication is no longer needed.
3. Stress the importance of avoiding substances containing aspirin, alcohol, nonsteroidal anti-inflammatory drugs, ibuprofen, and steroids, which might aggravate or precipitate further bleeding.
4. Discuss the importance of full participation with the medication regimen in order to promote healing and assure optimal comfort.

GIB –N NUTRITION

OUTCOME: The patient/family will understand the prescribed diet.

STANDARDS:

1. Explain that rest of the gastrointestinal tract may be required in the immediate GI bleed period.
2. Explain that IV nutrition support may be necessary if prolonged abstinence from food is required.
3. Explain that certain foods are likely to exacerbate the GI condition and should be avoided, i.e., alcohol, caffeine, fatty foods
4. Explain that gradual introduction of oral nutrients will be accomplished while decreasing IV nutrition support. Bowel irregularity is common during this period of time.
5. Explain that bland starchy foods are easier to digest and may be more easily tolerated.
6. Discuss that consumption of yogurt (with live or active cultures) is often helpful to resume normal bowel flora.

GIB –P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of gastrointestinal bleeding episodes.

STANDARDS:

1. Stress the importance of avoiding substances containing aspirin, alcohol nonsteroidal anti-inflammatory drugs, ibuprofen, and steroids, which might aggravate or precipitate bleeding.
2. Emphasize the importance of bowel regular bowel movements in the prevention of GI bleeds.

GIB-TE TESTS

OUTCOME: The patient/family will understand the diagnostic tests to be performed, the risk(s) and benefits of the proposed test as well as the risk(s) of non-performance of the test(s).

STANDARDS:

1. Explain that examining-a stool sample for occult blood is a simple and reliable method for determining subtle bleeding in the GI tract.
2. Explain that the cause of the bleeding may be found by directly visualizing the inside of the GI tract via an endoscope, a tube that is passed either by the mouth or the rectum.
3. Explain that sometimes defects of the GI tract that cause bleeding may be detected by x-ray by performing either a barium swallow or upper GI series or a barium enema.
4. Explain that the preparation for many of these procedures require that nothing be taken by mouth for several hours before the procedure, and enemas are usually required for the lower GI tests.
5. Explain that local anesthetics and sedation are usually given prior to the endoscopic procedures.

GIB-TX TREATMENT

OUTCOME: The patient/family will understand the appropriate management of the gastrointestinal bleeding.

STANDARDS:

1. Explain that IV fluids and/or blood transfusions may be necessary to replace lost blood volume. **Refer to BL.**
2. Explain that for upper GI bleeding, gastric lavage may be necessary to remove the blood from the GI tract and prevent further complications.
3. Explain that electrocoagulation or photocoagulation (laser) may be necessary to stop the bleeding.
4. Explain that surgery may be necessary to resect the bleeding area or tumor if other measures are not effective.

GBS—Guillain-Barre

GBS-C COMPLICATIONS

OUTCOME: The patient/family will understand the effects and consequences possible as a result of Guillain-Barre Syndrome and understand that fully participating in the plan of care may help prevent these complications.

STANDARDS:

1. Explain that because of decreased inspiratory and expiratory capacities, coughing may become ineffective and the airway compromised, leading to hypoxia, atelectasis, pneumonia and aspiration.
2. Explain that aspiration may also be the direct result of weakness of the laryngeal and glottic musculature, and that airway obstruction may occur as a result of tongue and retropharyngeal weakness.
3. Emphasize that changes in speech, tongue protrusion and swallowing problems are signs of impending respiratory dysfunction and should trigger an immediate visit to the healthcare provider.
4. Explain that another serious complication that can be treated with medications is cardiac rhythm disturbances.
5. Explain that other complications that are less serious, but still require treatment may be abnormal blood pressure, urinary retention, gastrointestinal dysfunction and fluid and electrolyte abnormalities.
6. Explain that common complications of paralysis such as pressure sores and contractures may be minimized or eliminated by careful attention to skin care, positioning and passive exercise.

GBS-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology, symptoms and prognosis of Guillain-Barre Syndrome.

STANDARDS:

1. Explain to the patient that Guillain-Barre' syndrome is an inflammatory disease with widespread involvement of the peripheral and cranial nerves. It usually affects young adults and persons in their 50s. There is a higher incidence in men and Caucasians. The cause of the syndrome is unknown, but many persons with this syndrome experience a mild respiratory or gastrointestinal infection 1 to 3 weeks before the onset of the neuritic signs and symptoms. Viral infections may function as a trigger to set off the autoimmune response to damage the peripheral nerves.
2. Explain that weakness usually begins in the distal muscles of the limbs, develops bilaterally over a period of a few days and ascends to the trunk, arms, and cranial muscles producing total motor paralysis within a few days (10 to 14 days.) This paralysis may involve the muscles of respiration and facial muscles so that the patient cannot breathe, chew, swallow, talk or open the eyes. Sensory symptoms may or may not be present.
3. Explain that muscle atrophy does not occur and the paralysis is usually temporary.
4. Explain that there is *usually* no pain, but tingling, burning, aching or cramping pain may occur.
5. Emphasize that recovery is usually total over time, but that convalescence may be lengthy and that recovery may continue from 3 months to 2 years.
6. Explain that there is a risk of recurrence. Persons who have experienced one episode of Guillain-Barre syndrome are at higher risk of another episode over the general population.

GBS-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment, as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment, as appropriate.
4. Participate in a return demonstration by the patient/family, as needed.
5. Discuss signs of equipment malfunction and proper action in case of malfunction, as appropriate.
6. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
7. Emphasize the importance of not tampering with any medical device.

GBS-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make plans to keep follow-up appointments and return immediately for signs of complications.

STANDARDS:

1. Stress the importance of keeping follow-up appointments and continuing the prescribed therapy even after the condition improves.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize the importance of keeping follow-up appointments.
4. Emphasize that changes in speech, tongue protrusion and swallowing problems are signs of impending respiratory dysfunction and should trigger an *immediate* visit to the healthcare provider or emergency facility.

GBS-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about Guillain-Barre Syndrome.

STANDARDS:

1. Provide the patient/family with written patient information regarding Guillain-Barre Syndrome.
2. Discuss the content of the patient information literature with the patient/family.

GBS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will strive to make the lifestyle adaptations necessary to prevent complications of Guillain-Barre Syndrome and improve mental and physical health.

STANDARDS:

1. Teach the patient to check his feet daily for injuries. Minor injuries may go unnoticed because of sensory impairment.
2. Stress that over fatigue which decreases accuracy of motor coordination should be avoided.
3. Explain that career counseling may be needed if recovery of neurologic function is prolonged.
4. Encourage the patient/family to contact the Guillain-Barre Syndrome Support Group, International, P.O. Box 262, Wynnewood, PA 19096 for more information, newsletters and a list of chapters.

GBS-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and be able to demonstrate and explain the use of the prescribed regimen.

STANDARDS:

1. Explain that the use of IV immunoglobulin has been found to reduce the clinical symptoms of Guillain-Barre Syndrome.
2. Explain that analgesics and muscle relaxants may be used for joint and muscle pain and muscle spasms.
3. Discuss the proper use, benefits, common side effects, and common interactions of the prescribed medications. Review the signs of possible toxicity and appropriate follow-up as indicated.
4. Emphasize the importance of fully participating in the medication regimen.
5. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
6. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

GBS-N NUTRITION

OUTCOME: The patient/family will understand the importance of maintaining or improving optimal nutritional status**.**

STANDARDS:

1. Explain that preventing or correcting weight loss that results in malnutrition is necessary to maintain optimal body function.
2. Explain that food textures may be modified as needed secondary to chewing or swallowing limitations (dysphagia).
3. Explain that it may be necessary to use oral supplements to meet energy needs. The use of vitamin/mineral supplements may be necessary.
4. As indicated, explain that nutrition may need to be maintained utilizing a feeding tube or parenteral nutrition during the most acute phases of illness.

GBS-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed including the indications and impact on further care.

STANDARDS:

1. Explain that a spinal tap may be indicated to test for protein, which is usually elevated with Guillain-Barre Syndrome.
2. Explain that nerve conduction studies may be performed. Slowing of conduction velocity in peripheral nerves is present with Guillain-Barre Syndrome and may be used to monitor the course of the disease.
3. Explain that periodic pulmonary function studies may be done to screen for respiratory compromise so special care can be implemented in a timely manner.
4. Explain the benefits and risks of the test to be performed and how it relates to the course of treatment.

GBS-TX TREATMENTS

OUTCOME: The patient/family will understand the possible treatments that may be available for Guillain-Barre Syndrome.

STANDARDS:

1. Explain that plasmapheresis produces temporary reduction in the circulating antibodies and sometimes an improvement in symptoms. Usually five exchanges are done within the first two weeks of symptoms for optimal results.
2. Explain that the treatment plan for Guillain-Barre Syndrome includes close monitoring of respiratory status and may include intubation and mechanical ventilation if the airway or respiratory status are compromised.
3. Explain that during the most acute phase, if indicated, cardiac monitoring will occur and dysrhythmias will be treated.
4. Explain that other treatment is supportive to prevent complications of immobility.
5. Emphasize that extensive rehabilitation is usually necessary for a full recovery.

H

HPS—Hantavirus Pulmonary Syndrome

HPS-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential consequences of exposure to and/or infection caused by the hantavirus.

STANDARDS:

1. Discuss the common or significant complications that may occur after infection with the hantavirus, such as cardiorespiratory failure and death.
2. Discuss if treatment is obtained before the disease progresses to acute respiratory distress, the chances of surviving are greatly increased.

HPS-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology, symptoms, and prognosis of infection with the hantavirus.

STANDARDS:

1. Explain that deer mice (along with cotton rats in the southeastern states and the white-footed mouse in the northeast) carry "hantaviruses" that cause hantavirus pulmonary syndrome (HPS). Explain rodents shed the virus in their urine, droppings, and saliva and the virus is mainly transmitted by people when they breathe in air contaminated by the virus.
2. Explain that following aerosol exposure and deposition of the virus deep in the lung, infection may be initiated. The virus attacks the lungs and infects the walls of the capillaries, making them leak, flooding the lungs with fluid.
3. Incubation time is not positively known but it appears that symptoms may develop between 1 and 5 weeks after exposure.
4. Explain that symptoms include:
    a. Early universal symptoms: fatigue, fever, and muscle aches, especially in the large muscle groups – thighs, hips, back, and sometimes shoulders.
    b. Other early symptoms: headaches, dizziness, chills, and abdominal problems, such as nausea, vomiting, diarrhea, and abdominal pain (about half of all HPS patients experience these symptoms).
    c. Late symptoms (4 to 10 days): coughing and shortness of breath, with the sensation of a "tight band around the chest and a pillow over the face" as the lungs fill with fluid.
5. Discuss that even though the mortality rate is near 50% (2004 data), the sooner an infected person gets medical treatment, the better the chance of recovery. Explain the need to see the doctor immediately for exposure to rodents and development of symptoms of fever, deep muscle aches and severe shortness of breath. Emphasize the need to tell your physician that you have been around rodents.

HPS-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Explain the use of equipment utilized to monitor the patient.
2. Explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
3. Emphasize, as necessary, that electrodes and sensors must be left in place in order for the equipment to function properly.
4. Encourage the patient/family to ask questions if they have concerns regarding equipment readings.
5. Emphasize the importance of not tampering with any medical equipment.

HPS-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

HPS-INT INTUBATION

OUTCOME: The patient/family will have a basic understanding of endotracheal intubation, as well as the risks, benefits, alternatives to endotracheal intubation and associated factors affecting the patient.

STANDARDS:

1. Explain the basic procedure for endotracheal intubation, including the risks and benefits of endotracheal intubation and the adverse events which might result from refusal.
2. Discuss alternatives to endotracheal intubation, including expectant management, as appropriate.
3. Explain that the patient will be unable to speak or eat while intubated.

HPS-L PATIENT EDUCATION LITERATURE

OUTCOME: The patient/family will receive written information about HPS.

STANDARDS:

1. Provide patient/family with written patient information on HPS.
2. Discuss the content of patient information literature with the patient/family.

HPS-P PREVENTION

OUTCOME: The patient/family will understand that HPS can be prevented by eliminating or minimizing contact with rodents.

STANDARDS:

1. Explain that rodents tend to be found in the home, cabin, workplace, orchards, out buildings, hay fields, or open fields.
2. Discuss the importance of keeping a clean and healthy home and yard to eliminate sources of nesting materials and sites.
3. Discuss the need to seal up the house to keep rodents out of the home. Examine for any gaps around roofing, attic spaces, vents, windows and doors as well as for gaps under the sink and locations where water pipes come into the home.
4. Discuss the common signs that point to a rodent problem (i.e., rodent droppings, rodent nests, food containers that have been "chewed on", gnawing sound, or an unusual musky odor).
5. Discuss the mode of transmission of HPS is inhalation of infected rodent feces so it is important to not stir up dust by sweeping up or vacuuming up droppings, urine or nesting material.
6. Discuss precautions to take when cleaning up rodents and rodent droppings including wearing rubber or plastic gloves and spray dead rodents, urine or droppings with a disinfectant or a mixture of bleach water. Explain that contaminated gloves must be disinfected with a disinfectant or soap and warm water before taking them off
7. Explain the need to thoroughly wet contaminated areas with a disinfectant to deactivate the virus. Most general purpose disinfectants and household detergents are effective. A solution prepared by mixing 1 and ½ cups of household bleach in 1 gallon of water may be used in place of commercial disinfectant. Take up contaminated materials with a damp towel, then mop or sponge the area with disinfectant.
8. Discuss that when going into cabins or outbuildings that have been closed up for awhile should be opened and aired before cleaning due to the high probability of rodent infestation and the possibility of aresolization of dropping and/or urine.

HPS-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Discuss the necessity, benefits and risks of the test to be performed, as appropriate, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of diagnosis and treatment.
4. Explain any necessary preparation for the test.
5. Discuss the meaning of the test results, as appropriate.

HPS-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available for HPS.

STANDARDS:

1. Explain to patient/family that there is currently no virus-killing drug that is effective against HPS.
2. Explain that there is no specific treatment or "cure" for hantavirus infection. If the infected individuals are recognized early and admitted to intensive care, the chance for recovery is better.
3. Emphasize that treatment is supportive care.

HPS-VENT MECHANICAL VENTILATION

OUTCOME: The patient/family will understand mechanical ventilation, as well as the risks, benefits, alternatives to mechanical ventilation and associated factors affecting the patient.

STANDARDS:

1. Explain that the patient must be intubated with an endotracheal tube or tracheostomy tube in order to receive mechanical ventilation.
2. Explain the basic mechanics of mechanical ventilation, including the risks and benefits of receiving mechanical ventilation and the adverse events which might result from refusal.
3. Discuss alternatives to mechanical ventilation, including expectant management, as appropriate.
4. Explain that the patient will be unable to speak or eat while intubated and receiving mechanical ventilation.
5. Explain that the patient will be sedated during intubation and the initiation of mechanical ventilation.
6. Discuss the possibility that the patient may require restraints to prevent accidental extubation.

HA—Headaches

HA-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand the basic the AP of their particular type of headache.

STANDARDS:

1. Explain that headaches are multifactorial and the pathophysiology is dependant on the disease process.
2. Discuss the pathophysiogoly and related anatomy of this patient disease process.

HA-C COMPLICATIONS

OUTCOME: The patient/family will understand the effects and consequences possible as a result of headaches, failure to manage headaches, or as a result of treatment.

STANDARDS

1. Discuss the possible complications, including:
    a. Depression or other mood disorders
    b. Suicidal behaviors
    c. Domestic violence
    d. Substance abuse
    e. Substance use
    f. Employment problems.
    g. Relationship problems
    h. Cognitive difficulties
    i. Appetite change
    j. Sensitivity to light and noise
    k. Alteration in sleep patterns

HA-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the headache pain symptoms, type (migraine, tension, sinus, or cluster) and the causes if known.

STANDARDS:

1. Explain that the patient is the primary source of information about the pain's location, quality, intensity, onset, precipitating, or aggravating factors, frequency of headache pain and the measures that bring relief.
2. Discus the current knowledge of this patient's type of headache.
3. Emphasize the importance of communicating information about the headache to the provider.
4. Discuss that the patient's presentation of symptoms is a unique combination of the type of pain, individual experiences and sociocultural adaptive responses.
5. Explain that headache pain may act as a warning sign of some problems in the body, including:
   a. Sinus problems
   b. Dehydration
   c. Decayed teeth
   d. Problems with eyes, ears, nose or throat
   e. Infections and fever
   f. Injury to the head
   g. Physical or emotional fatigue
   h. Exposure to toxic chemicals
   i. High blood pressure
   j. Sleep apnea
   k. Mood disorders
   l. Caffeine withdrawal (i.e., coffee, chocolate, tea, soft drinks)
   m. Hangovers
   n. Tumor (extremely rare)
6. Emphasize that influencing factors from internal and external changes are present. Some of these factors include:

Internal Factors:	**External Factors:**
Hormonal changes	Weather changes
Stress	Alcohol
Change in sleep habit	Bright /flickering light

HA-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.
4. Discuss important warning signs that would indicate earlier follow up is needed, including:
    a. If the headache keeps you from your usual activities
    b. If the headache lasts more than one day
    c. If you have fever, stiff neck, nausea, or vomiting
    d. If you feel drowsy or want to go to sleep
    e. If you have had a recent head injury
    f. If you develop eye pain, blurred vision, or trouble seeing
    g. If you suspect the headache was caused by medicines
    h. If you have persistent headaches seen by doctor
    i. If the headache was the result of a head injury
    j. If you have difficulty speaking
    k. If you develop numbness or weakness of the arms or legs
    l. If the headaches increase in intensity or frequency over time
    m. If you experience instantaneous onset of severe headache
    n. If the headaches require the daily use of pain-reliever medications
    o. If the headache is experienced by very young children (preschool age)
    p. If there is new onset headaches in middle-aged people.

HA-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient /family will receive written information about headache pain.

STANDARDS:

1. Provide the patient/family with written patient information literature.
2. Discuss the content of the patient information literature with the patient/family.

HA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle changes necessary to optimize performance of everyday activities and promote well-being.

STANDARDS:

1. Explain that treatment of headache pain is very individualized and may involve lifestyle adaptation, i.e., medication, rest and relaxation, exercise, stress-reduction, and/or internal or external changes.
2. Explain that exercise and social involvement (i.e., familial, traditional, cultural) may decrease the sense of pain and the depression and anger associated with pain.
3. Review lifestyle areas that may require adaptations, i.e., diet, substance use, rest and sleep patterns, physical activity, sexual activity, role changes, communication skills and interpersonal relationships.
4. Discuss lifestyle changes in relation to headache style.
5. Discuss techniques that may reduce stress and depression, such as meditation, maintaining regular sleep patterns, exercise program, hobbies and crafts, acupuncture, spiritual and cultural activities, or biofeedback training.
6. Refer to community resources as appropriate.

HA-M MEDICATION

OUTCOME: The patient/family will understand their medication regimen and the importance of fully participating with the therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications.
2. Discuss that there are many medications for the treatment or prevention of headaches and that narcotics are usually not indicated.
3. Explain that excess sedation and euphoria are not goals of palliative pharmacotherapy.
4. Emphasize that headache pain is not always completely understood and it is often necessary to take prophylactic medicines to assure optimal comfort levels. It is important to take preventive medication exactly as prescribed to prevent or reduce pain.
5. Discuss patient/family concerns about addiction. Explain the difference between psychological addiction and physical dependence upon prescribed medications. Reinforce that addiction is psychological dependence on a drug and is not equivalent to tolerance or physical dependence.
6. Emphasize the importance of consulting with provider before taking any OTC or herbal/traditional remedies.
7. Discuss the use of adjunct medications, if indicated, to control analgesic side effects, i.e., anti-emetics, laxatives, antacids.

HA-N NUTRITION

OUTCOME: The patient/family will understand the important contribution of healthy food choices and an adequate fluid intake in the treatment of headaches. They will be able to identify some dietary factors that may affect their headaches.

STANDARDS:

1. Assess eating habits.
2. Stress that eating regularly and not skipping meals is important.
3. Emphasize the necessary component – water – in a healthy diet.
4. Explain that constipation is a common side effect of some pain medications. Dietary measures such as increased water, increased fiber, increased fruit and decreased intake of milk products may be helpful.
5. Refer to dietitian or other local resources as indicated.

HA-P PREVENTION

OUTCOME: The patient/family will understand that headaches have varying etiologies and the mechanisms are not known for many headaches. The patient/family will identify the precipitating factors, if known, and develop a plan to maximize prevention strategies.

STANDARDS:

1. Discuss strategies for identifying headache triggers (i.e., journal, activity and food log).
2. Stress the importance of avoiding any known triggers.
3. Discuss that prophylactic medications must be taken as directed to be effective.
4. Emphasize that headaches seem to be more common during stressful times. **Refer to HA-SM.**

HA-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand that grief reactions and mood disorders are common with chronic headaches.

STANDARDS:

1. Discuss symptoms of mood disorders that may need additional professional support, sympathy, time, attention, compassion, and communication for patient/family.
2. Explain that if anti-depressant drugs are prescribed by the provider, full participation with the treatment plan is important to maximize the effectiveness of the treatment.
3. Explain that many mechanisms for dealing with grief and depression are available, i.e., support groups, individual therapy, family counseling, spiritual guidance.
4. Refer to community resources as appropriate.

HA-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in headache management.

STANDARDS:

1. Explain that uncontrolled stress may exacerbate the symptoms of headache. This can set up a cycle of pain-stress which becomes self-sustaining and may escalate.
2. Discuss that in chronic headaches, uncontrolled stress may lead to depression or other mood disorders.
3. Explain that effective stress management may reduce the severity of symptoms the patient experiences, as well as help improve the health and well-being of the patient.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as inappropriate eating, all which can increase the severity of pain.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

HA-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Explain the test ordered.
2. Discuss the necessity, benefits and risks of the test to be performed, as appropriate, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Discuss the meaning of the test results, as appropriate.

HA-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available based on the specific history, test results, and individual preferences.

STANDARDS:

1. Discuss with the patient/family the possible appropriate noninvasive pain relief measures, i.e., massage, heat, cold, rest, over-the-counter medications, books or tapes for relaxation.
2. Discuss with the patient/family the possible alternative pain relief measures, when appropriate, i.e., meditation, imagery, acupuncture, healing touch traditional healer, biofeedback, hypnosis.
3. Discuss with the patient/family the possible appropriate pharmacotherapy. **Refer to HA-M.**
4. Discuss with the patient/family other possible approaches, i.e., lifestyle changes, physical therapy, nutritional changes, stress management, or psychotherapy.
5. Emphasize the importance of the patient/family's active involvement in the development of a treatment plan.

HEAT—Heatstroke

HEAT-C COMPLICATIONS

OUTCOME: The patient and/or family will understand the consequences of heat stroke and the complications associated with heatstroke.

STANDARDS:

1. Explain that the body tissues and cells breakdown (denaturization of enzymes, destabilization of cells and breakdown of metabolic pathways) when the body's temperature increases above 105.8˚ F (41˚ C).
2. Discuss the complications of multisystem failure and the risks of morbidity and mortality that can occur as a result of heatstroke.
3. Discuss the possibility of circulatory collapse, which may precede permanent brain damage or death.

HEAT-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

HEAT-DP DISEASE PROCESS

OUTCOME: The patient and/or family will understand how heat stroke occurs and the signs and symptoms of heatstroke.

STANDARDS:

1. Discuss the two different categories of heatstroke: exertional and non-exertional.
2. Discuss signs and symptoms of heatstroke with the patient:
   a. headache
   b. vertigo
   c. fatigue
   d. decreased sweating
   e. skin warm to touch
   f. flushing
   g. increased heart rate
   h. increased respiratory rate.
3. Discuss the pathophysiology of heat stoke: inadequacy or failure of the heat loss mechanism.
4. Discuss warning signs of heat stroke: headache, weakness, and sudden loss of consciousness.
5. Discuss with the patient that heatstroke is an emergency.
6. Explain that some disease states or conditions may predispose to heat stroke, i.e., diabetes, anhydrosis or previous episodes of heat stroke.
7. Explain that environmental conditions such as high humidity, extremely high temperatures can predispose to heat stroke.
8. Discuss that tight clothing or spandex or rubber clothing can predispose to heat stroke.

HEAT-EX EXERCISE

OUTCOME: The patient and/or family will understand how heatstroke can be influenced by exercise.

STANDARDS:

1. Discuss with patient/family how exercising in a warm environment, excessive exercising and prolonged exercise and exertion can lead to heatstroke.
2. Discuss the importance of frequent hydration and rest when exercising in a warm environment.

HEAT-FU FOLLOW-UP

OUTCOME: The patient and/or family will understand the seriousness of heatstroke and the importance of follow up care.

STANDARDS:

1. Discuss the importance of follow up appointments after a heat stroke to determine if there is any permanent or ongoing damage.
2. Discuss the importance of keeping follow up appointments.
3. Discuss the procedures for obtaining follow up appointments.

HEAT-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient and/or family will receive written information about heatstroke, and important preventive measures.

STANDARDS:

1. Provide patient/family with written information on heatstroke and prevention of heatstroke.
2. Discuss the content of heatstroke written information with the patient/family.

HEAT-M MEDICATIONS

OUTCOME: The patient/family will understand the use of medications in the emergency room to manage heatstroke.

STANDARDS:

1. Discuss with the patient that pharmacological therapy may not be required.
2. Discuss with the patient that signs/symptoms such as dysrhythmia and shivering may occur as a complication of heatstroke and may require medication therapy.
3. Discuss with the patient that once they leave the hospital they may require medications that will treat the complications that have occurred from the heatstroke.
4. Discuss with the patient the importance of following the instructions in regards to their medications.
5. Discuss the common and important side effects and drug interactions of the medications prescribed.

HEAT-N NUTRITION

OUTCOME: The patient/family will understand the importance of adequate hydration and that water is the beverage of choice.

STANDARDS:

1. Explain that water is the beverage that best hydrates the body.
2. Discuss that caffeinated beverages and alcohol are especially dangerous and may predispose to dehydration and heat stroke.

HEAT-P PREVENTION

OUTCOME: The patient/family will understand ways to prevent heatstroke.

STANDARDS:

1. Discuss that it is easier to prevent heat stroke than to treat it.
2. Discuss with the patient/family that the majority of heat stroke cases are preventable by avoiding extremely hot/humid environments, inadequately ventilated spaces, inadequate fluid intake and heavy clothing in warm conditions.
3. Discuss with the patient/family ways to prevent heatstroke when heat exposure cannot be avoided; reducing or eliminating strenuous activities, staying adequately hydrated, frequently taking showers, wearing light weight clothing and avoiding direct sunlight.
4. Discuss that up to a liter an hour may be required to prevent dehydration and predispose to heat stroke.
5. Discuss with the patient the most likely time of year to develop heatstroke: summer.
6. Discuss with patient the risk factors such as increased age, debility, low fluid intake, excessive exercise, alcohol and drug use, chronic disease, living conditions with no air-conditioning, travel to warmer climates, and prolonged outdoor activities.

HEAT-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

HEAT-TX TREATMENT

OUTCOME: The patient and/or family will understand the management and treatment of heatstrokes.

STANDARDS:

1. Discuss the importance of seeking emergency care if heatstroke is suspected.
2. Discuss the importance of slowly decreasing the temperature of the person.
3. Discuss the management of heatstroke in the emergency department; protection of airway, intravenous administration of fluids, monitoring of temperature, decreasing of temperature, and monitoring of cardiorespiratory status.
4. Discuss the goal of treatment with the patient; prevention of further heat loss, decrease in the core body temperature, and management and prevention of complications.
5. Discuss with the patient/family the importance of seeking emergency help as soon as possible in the incidence of a heatstroke.
6. Discuss the probability that the person experiencing a heatstroke may be admitted to an intensive care unit for extensive monitoring.

HEP—Hepatitis A,B,C

HEP-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family/caregiver will understand the basic function of the liver and its relationship to hepatitis.

STANDARDS:

1. Briefly identify and explain the function of the liver.
2. Discuss the liver's role in detoxifying and cleansing the body.
3. Explain the word "hepatitis" means inflammation of the liver.
4. Explain that common viral infections that affect the liver include Hepatitis A, Hepatitis B, and Hepatitis C.

HEP-C COMPLICATIONS

OUTCOME: The patient , family & caregiver will understand the long term consequences of viral infections with HAV, HBV, and HCV. The patient will learn how to protect the liver from further harm.

STANDARDS:

1. Explain that most persons who get HCV carry the virus the rest of their lives and most of these have some liver damage. Some may develop cirrhosis (scarring) of the liver or liver failure.
2. Discuss ways to care for the liver:
   a. Avoid alcoholic beverages
   b. Inform your provider of all the medications, even over the counter and herbals medication
   c. Have regular doctor visits
   d. Get vaccinated against Hepatitis A and B.
3. Explain that the most common symptom with long term hepatitis C is extreme tiredness.

HEP-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

HEP-DPA DISEASE PROCESS HEPATITIS A

OUTCOME: The patient/family or caregiver will understand that hep A is an inflammation of the liver caused by hepatitis A virus (HAV).

STANDARDS:

1. Explain that the symptoms of HAV infection will usually last for about 3 weeks.
2. Discuss that the patient's symptoms may include fever, nausea, vomiting, jaundice, diarrhea, fatigue, abdominal pain, dark urine and appetite loss.
3. Emphasize that other symptoms such as respiratory symptoms, rash and joint pain may also develop.
4. Explain to the patient/family that in the early stages of infection the virus is easily transmitted to others by contact with body fluids and excrements (usually fecal/oral route).
5. Explain that in children the disease is usually mild and may even be asymptomatic.

HEP-DPB DISEASE PROCESS- HEPATITIS B

OUTCOME: The patient, family or caregiver will understand that hepatitis B is an inflammation of the liver caused by infection with Hepatitis B virus (HBV).

STANDARDS:

1. Review the transmission modes, known risk groups and child exposure.
2. Discuss the symptoms of acute HBV: nausea, vomiting, jaundice, rash, abdominal pain, malaise, fever may be absent or mild.
3. Discuss that following acute infection with HBV one may become a carrier, resolve the disease, or develop chronic Hepatitis B.
4. Discuss the symptoms of chronic HBV: including malaise, anorexia, weight loss, fatigue, cirrhosis and predisposition to liver cancer.
5. Explain that HBV is a blood born pathogen and is spread by contact with contaminated blood or other body fluids. The most common ways to get it are through unprotected sex, sharing needles, sharing personal items, or by perinatal transmission.

HEP-DPC DISEASE PROCESS HEPATITIS C

OUTCOME: The patient, family or caregiver will understand that hepatitis C is a liver disease caused by infection with Hepatitis C virus (HCV) which is found in the blood of persons with the disease. Formerly called non-A, non-B is the most common chronic blood borne viral infection.

STANDARDS:

1. Explain that Hepatitis C is an infection transmitted primarily by blood. 85% of persons infected with HCV cannot clear the infection and the virus continues to multiply in the body. As a result, chronic infection occurs and may be contagious.
2. Discuss the primary risk factors associated with HCV, i.e., sharing needles when injecting drugs and exposure to blood in the health care setting. Sexual transmission may occur but is low. Blood transfusion associated cases are now rare.
3. Discuss the signs and symptoms of HCV: jaundice, fatigue, abdominal pain, loss of appetite, and bouts of nausea and vomiting. (1 in 10 people will have symptoms when initially infected).
4. Differentiate between acute and chronic infection. Note that it could be years before person with chronic infection may experience symptoms serious enough to prompt seeking medical care. Consequences may appear 10-20 years after infection.
5. Discuss that chronic HCV may result in cirrhosis and/or liver cancer.

HEP-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand the need for keeping appointments for medical follow-up and immunization as appropriate.

STANDARDS:

1. Explain that persons with hepatitis C may need to consider immunization against Hepatitis A and B to prevent further liver damage.
2. Discuss the importance of follow-up care.
3. Encourage the patient to keep follow-up appointments.
4. Refer to community resources as appropriate.

HEP-L LITERATURE

OUTCOME: The patient/family or caregiver will receive written information about hepatitis, vaccine information or preventive measures.

STANDARDS:

1. Provide patient/family with written information on hepatitis, vaccine information and/or preventive/protective measures.
2. Discuss protective and risk reduction measures and provide written information.

HEP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adaptations necessary for healing and performance of daily living activities.

STANDARDS:

1. Review lifestyle areas that may require adaptations such as:
    a. sexual activity
    b. traveling
    c. avoiding alcohol use and illegal drug use
    d. avoid intake of foods that may be at high risk for transmission of Hepatitis A.

HEP-M MEDICATION

OUTCOME: Patient/Family with understand medications to manage hepatitis.

STANDARDS:

1. Review the proper use, benefits and common side effects of the prescribed medication.
2. Emphasize the importance of adhering to medication regimen.
3. Emphasize the importance of possible drug interactions with foods, drugs, herbals, oral nutritional supplements, over the counter medications, as appropriate.

HEP-N NUTRITION

OUTCOME: The patient/family will understand the importance of a nutritionally balanced diet in the treatment of the disease. They will be able to identify foods and a meal plan that will promote the healing process if applicable.

STANDARDS:

1. Discuss current nutritional habits and needs. Address anorexia and weight loss as appropriate.
2. Emphasize the necessary component, water, in a healthy diet.
3. Review the patient's prescribed diet if applicable.
4. Refer to registered dietician or other local resources as indicated.

HEP-P PREVENTION

OUTCOME: The patient/family/caregiver will understand the modes of transmission, ways to prevent acquiring the virus.

STANDARDS:

1. The best way to prevent exposure to virus is by careful hand washing. Review standard precautions for use by child care workers, health care workers, corrections officers and food service workers.
2. Discuss immunization against Hepatitis A and B as methods of prevention.
3. Explain that there is no vaccine for prevention of hepatitis C.
4. Discuss the use of immunoglobulin against Hep A and B for post exposure prophylaxis.
5. Explain that hepatitis A is generally spread by fecal - oral route. Careful hand washing is paramount.
6. Explain that hepatitis B and C are spread by blood contact. Standard precautions are paramount. Do not share personal items such as toothbrushes, razors, or needles.
7. Hepatitis B can be spread by sexual transmission. Adequate protective barriers are important.
8. Persons with hepatitis should not donate plasma, blood, sperm or organs as this may spread the virus to others.

HEP-TE TESTS

OUTCOME: The patient/family or caregiver will understand the importance of testing.

STANDARDS:

1. Discuss the need for testing if you think you have been exposed to hepatitis A, B, or C.
2. Explain that if you test positive, further testing may be necessary.

HEP-TX TREATMENT

OUTCOME: The patient/family or caregiver will understand treatment for Hepatitis A, B or C.

STANDARDS:

1. Explain that some antiviral medications may be helpful in the treatment of hepatitis.
2. Discuss current treatment options.
3. Discuss the importance of protecting the liver from further harm by not drinking alcohol, getting vaccinated against hepatitis A and B.
4. Advise against starting any new prescription or over the counter medication, herbal products, and oral nutritional supplements without first discussing hepatitis status with the provider.
5. Emphasize the importance of rest and proper nutrition in recovery from hepatitis.

HIV—Human Immunodeficiency Virus

HIV-C COMPLICATIONS

OUTCOME: The patient and/or family will understand the effects and consequences possible as a result of HIV/AIDS, failure to manage this disease state/condition, or as a result of treatment.

STANDARDS:

1. Discuss the common or significant complications associated with HIV/AIDS:
   a. Bacterial infections;
   b. Viral infections;
   c. Fungal infections;
   d. Parasitic infections;
   e. Cancers.
2. Discuss common or significant complications which may be prevented by full participation with the treatment regimen.
3. Discuss common or significant complications that may result from treatment(s).

HIV-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

HIV-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the risk factors, methods of transmission and prevention of HIV (Human Immunodeficiency Virus) and the progression from HIV positive status to AIDS (acquired immunodeficiency syndrome).

STANDARDS:

1. Explain the methods of HIV transmissions, i.e., semen, blood and blood product transfusions, needle sharing, accidental needle sticks, vaginal fluids, mother to infant, and in rare cases, organ or tissue transplants and unsterilized dental or surgical equipment.
2. Explain that HIV is a virus and there is no current vaccine to prevent its occurrence.
3. Explain that the human immunodeficiency virus attacks the immune system resulting in increased susceptibility to infections and cancers.
4. Explain the difference between HIV infection and AIDS. Explain that it is currently believed that all HIV infections will progress to AIDS. Early treatment and strict participation may slow the progression from HIV infection to AIDS.
5. Some symptoms of AIDS may be unusual or more frequent infections that are especially difficult to treat.
6. Explain the current knowledge about the progression of HIV and AIDS.

HIV-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

HIV-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand the importance of follow-up and testing as appropriate and will formulate a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care with referral resources and assistance from HIV case managers.
2. Discuss the procedure for accessing health care resources for HIV positive patients.
3. Discuss importance of follow-up appointments and follow-up testing as appropriate for this patient if initial or repeat HIV tests are negative.
4. Refer as appropriate to community resources.

HIV-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand how to manage HIV/AIDS at home.

STANDARDS:

1. Discuss the risks and benefits of the use of over the counter medications for symptom relief.
2. Discuss the use of alternative therapies or complementary medicinals that may be useful in symptom relief.
3. Help the patient/family identify appropriate resources for managing HIV/AIDS at home.

HIV-HY HYGIENE

OUTCOME: The patient will recognize good personal hygiene as an important component of preventing complications.

STANDARDS:

1. Discuss hygiene as part of a positive self image.
2. Review bathing and daily dental hygiene habits, i.e., don't share razors and toothbrushes.
3. Discuss the importance of hand washing in infection control.
4. If using IV drugs, discuss the importance and implications of not sharing needles; discuss the proper disposal of used needles.
5. Discuss the importance and implications of preventing unprotected sexual activity:
    a. Use a new latex or polyurethane condom every time you have vaginal or anal sex. Condoms other than latex or polyurethane are not effective in the prevention of HIV.;
    b. During oral sex use a condom, dental dam or plastic wrap;
    c. If you use sexual devices, don't share them;
    d. Don't share razor blades or tooth brushes
6. Discuss any hygiene habits that are specifically pertinent to this disease state or condition.

HIV-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family/caregiver will receive written information about HIV and other sexually transmitted infections (STIs).

STANDARDS:

1. Provide the patient/family with written patient information literature on HIV and/or other sexually transmitted infections.
2. Discuss the content of patient information literature with the patient/family.
3. Caution the patient that information found on the Internet is not necessarily screened for accuracy and may not be correct. Emphasize the importance of using reliable sources of information.

HIV-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will strive to make the lifestyle adaptations necessary to prevent complications of the disease state or condition or to improve mental or physical health.

STANDARDS:

1. Review lifestyle aspects/changes that the patient has control over - diet, exercise, safety and injury prevention, avoidance of high risk behaviors, and full participation with treatment plan:
   a. Follow safer sex practices
   b. Tell your sexual partner(s) that you have HIV
   c. If your partner is pregnant, tell her you have HIV
   d. Tell others who need to know, i.e., family, friends, health providers
   e. Don't share needles or syringes
   f. Don't donate blood or organs
   g. If you are pregnant, get medical care right away
2. Emphasize that an important component in the prevention or treatment of disease is the patient's adaptation to a healthier, lower risk lifestyle.
3. Emphasize the importance of not smoking, using illegal drugs, or alcohol as these further weaken your body.
4. Review the community resources available to assist the patient in making lifestyle changes. Refer as appropriate.

HIV-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
2. Emphasize the importance of fully participating with the prescribed medication regimen.
3. Discuss the mechanism of action as needed.
4. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
5. Emphasize the importance of providing a list of all current medications, including non-prescription, complementary medicine or traditional remedies, to the provider.

HIV-N NUTRITION

OUTCOME: The patient will understand the need for balanced nutrition and plan for the implementation of dietary modification if needed.

STANDARDS:

1. Discuss the fact that wasting syndrome is a serious, yet common, complication that can be prevented or minimized by maximizing nutrition.
2. Review nutritional needs for optimal health when living with HIV/AIDS. The patient/family will understand that fighting an infection (HIV) requires maximizing dietary intake.
3. Discuss current nutritional habits. Assist the patient in identifying health promoting nutritional habits.
4. Discuss nutritional modifications as related to the specific disease state/condition, especially in regards to fluid, protein and calories.
5. Emphasize the importance of fully participating in the prescribed nutritional plan.
6. Emphasize the importance of food safety.
7. Discuss nutrition supplements, i.e., vitamin and mineral supplements, antioxidants, complementary supplements.

HIV-P PREVENTION

OUTCOME: The patient will develop a healthy behavior plan, which will prevent/reduce exposure to HIV infections.

STANDARDS:

1. List circumstances/behaviors that increase the risk of HIV infection:
   a. IV drug use and sharing needles.
   b. Multiple sexual partners.
   c. Unprotected sex, i.e., sex without latex or polyurethane condoms or other protective agents, dental dams, plastic wrap.
   d. Anal intercourse
   e. Breastfeeding by an HIV infected mother
   f. Being born to an HIV infected mother
   g. Presence or history of another sexually transmitted infections
   h. Victims of rape
   i. Involvement in a abusive relationship.
2. Describe behavior changes which prevent/reduce transmission of HIV virus.
3. Discuss/demonstrate proper application of condom with model if available. Discuss proper lubricant type. (No oil based lubricants.)
4. Describe how alcohol/substance use can impair judgment and reduce ability to use protective measures.
5. Explain ways to reduce exposure to infected persons.
6. Explain that the best way to prevent exposure to HIV is to abstain from risky sexual behavior and from recreational drug use.

HIV-PN PRENATAL

OUTCOME: The patient/family will understand risk factors for HIV (mother and child) and offer referral for testing.

STANDARDS:

1. Discuss risk factors for HIV (mother and child).
2. Offer referral for HIV testing.
3. Explain that early detection, early treatment and full participation with the medication regimen as well as maintaining a healthy lifestyle will often result in a better quality of life and slower progression of the disease and may have beneficial effects upon the delivery and longevity of the child.

HIV-S SAFETY

OUTCOME - The patient/family/caregiver will understand principles of planning and living within a safe environment.

STANDARDS:

1. Explain that opportunistic infections are a major cause of death.
2. Discuss the need to prevent opportunistic infections through creating and living within a safe environment.
3. Assist the patient/family/caregiver in identifying ways to adapt the home to improve safety and prevent injury, illness and disease transmission appropriate to the patient's age, disease state and condition.
4. Identify which community resources promote a safe living environment.

HIV-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in HIV/AIDS.

STANDARDS:

1. Explain that uncontrolled stress can contribute to a suppressed immune response and increased complications from HIV/AIDS.
2. Explain that effective stress management may help to reduce the adverse consequences of HIV/AIDS, as well as improve the patient's health and well-being.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance abuse, all which can increase the risk of morbidity and mortality from HIV/AIDS.
4. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
5. Discuss suggestions for dealing with the emotional toll of living with HIV/AIDS:
    a. Learn all you can about HIV/AIDS;
    b. Be proactive, take an active role in your treatment;
    c. Maintain a strong support system;
    d. Take time to make important decisions concerning your future;
    e. Come to terms with your illness.
6. Provide referrals as appropriate.

HIV-TE TESTS

OUTCOME: The patient/family will understand the reason for testing, the expected outcome and whether the test will be confidential or anonymous.

STANDARDS:

1. Explain that early detection, early treatment and full participation with the medication regimen as well as maintaining a healthy lifestyle will often result in a better quality of life and slower progression of the disease.
2. Explain that identification of all partners is necessary to facilitate the treatment of those persons and limit further spread of the infection.
3. Explain that if you receive a diagnosis of HIV/AIDS, your doctor will use a test to help predict the probable progression of your disease. This test measures the amount of virus in your blood and aids in determining your course of treatment.
4. Emphasize the importance of using only approved test kits for HIV (as of November 2004 is the Home Access HIV test marketed by Home Access Health).

HIV-TX TREATMENT

OUTCOME: The patient/family will understand the importance of a comprehensive treatment plan.

STANDARDS:

1. Explain that according to current guidelines, treatment should focus on achieving the maximum suppression of symptoms for as long as possible. This aggressive approach is known as high active antiretroviral therapy (HAART). The aim of HAART is to reduce the amount of virus in your blood to very low levels, although this doesn't mean the virus is gone.
2. Emphasize and discuss the importance of a comprehensive treatment plan, which includes health and risk assessment, common lab tests, disease staging, prophylaxis therapy, immunizations, social and insurance needs, plus follow up.
3. Discuss the process for developing a comprehensive treatment plan.
4. Help the patient/family identify the appropriate resources for developing a comprehensive treatment plan.
5. Explain that identification of all partners is necessary to facilitate the treatment of those persons and limit further spread of the infection.

HTN—Hypertension

HTN-C COMPLICATIONS

OUTCOME: The patient will understand the complications of uncontrolled hypertension.

STANDARDS:

1. Explain that arteriosclerosis and atherosclerosis impede blood flow through the circulatory system.
2. Explain that heart attacks may result from the heart having to work harder to pump blood through congested and hardened arteries.
3. Explain that blindness may result from injured blood vessels in the eye.
4. Explain that strokes may result from ruptures of injured blood vessels in the brain.
5. Explain that circulatory complications eventually impair the ability of the kidneys to filter out toxins.

HTN-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

HTN-DP DISEASE PROCESS

OUTCOME: The patient will understand hypertension and summarize its causes.

STANDARDS:

1. Explain the difference between systolic and diastolic pressure. Define the normal ranges.
2. Review causative factors:
   a. Lifestyle Factors: Obesity, high sodium intake, high fat and cholesterol intake, lack of regular exercise
   b. Special Conditions: Pregnancy, oral contraceptives
   c. Disease States: Diabetes, hyperthyroidism
   d. Personal Factors: Family history, sex, race.
3. Discuss that most hypertension is asymptomatic, but some patients may experience headache, dizziness, faintness, nosebleed, or ringing in the ears and any of these symptoms should prompt immediate re-evaluation by a physician.

HTN-EQ EQUIPMENT

OUTCOME: The patient/family will receive information on the use of home blood pressure monitors.

STANDARDS:

1. Provide the patient/family with information on the use of the specific home blood pressure monitor.
2. Discuss the use of blood pressure monitoring equipment in public places, i.e., stores.
3. Discuss when to contact a health care provider for a blood pressure value which is outside the patient's personal guidelines.

HTN-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in this patient's disease process and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain how regular exercise helps to reduce high blood pressure and maintain normal blood pressure.
2. Discuss activity allowances and expectations (heavy lifting may predispose to complications).
3. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
4. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
5. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
6. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
7. Discuss medical clearance issues for physical activity.

HTN-FU FOLLOW-UP

OUTCOME: The patient participates in the treatment plan and understands the importance of full participation .

STANDARDS:

1. Discuss the individual's responsibility in the management of hypertension.
2. Encourage regular blood pressure and weight checks.
3. Review treatment plan with the patient, emphasizing the need to keep appointments, take medication as directed, make indicated lifestyle changes, and control co-morbid conditions.

HTN-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about hypertension.

STANDARDS:

1. Provide the patient/family with written patient information literature on hypertension.
2. Discuss the content of the patient information literature with the patient/family.

HTN-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle adjustments necessary to maintain control of blood pressure and develop a plan to modify his/her risk factors.

STANDARDS:

1. Emphasize the importance of weight control.
2. Discuss the importance of a program of regular exercise.
3. Discuss the relationship of stress to hypertension. Suggest ways of reducing stress—napping, meditation, exercise and "just relaxing."
4. Explain that use of tobacco, either smoking or use of smokeless tobacco, can worsen hypertension and increase the risk of complications.

HTN-M MEDICATIONS

OUTCOME: If on medication, the patient will verbally summarize their medication regimen and the importance of full participation with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications.
2. Explain the importance of avoiding over-the-counter medications without checking with a physician.

HTN-N NUTRITION

OUTCOME: The patient will verbally summarize methods for control of blood pressure through weight control and diet modification.

STANDARDS:

1. Explain the role of salt intake in hypertension and ways to decrease salt intake:
   a. Remove the salt shaker from the table
   b. Taste food before salting
   c. Discuss other seasonings
   d. Read food labels to determine sodium content.
2. Discuss caffeine and its role in hypertension.
3. Discuss the importance of weight loss in controlling hypertension**. Refer to WL-N.**
4. Encourage adequate intake of fruits, vegetables, water and fiber.

HTN-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in hypertension.

STANDARDS:

1. Explain that uncontrolled stress can worsen hypertension and increase risk factors of cardiovascular disease.
2. Explain that uncontrolled stress can interfere with the treatment of hypertension.
3. Explain that effective stress management may reduce the adverse consequences of hypertension, as well as help improve the health and well-being of the patient.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality from hypertension.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

HTN-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

HTH—Hyperthyroidism

HTH-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the anatomy and physiology of the pituitary-thyroid axis.

STANDARDS:

1. Explain the normal location, function, and feedback mechanism of the pituitary-thyroid axis (heart rate, muscle strength, bowel function, fat metabolism, energy level, hair growth, and mood).
2. Discuss the changes to the thyroid gland and the body's metabolic state as a result of hypothyroidism.
3. Discuss the impact of these changes on the patient's health and well-being.

HTH-C COMPLICATIONS

OUTCOME: The patient/family will understand the effects and consequences possible as a result of hyperthyroidism, failure to manage hyperthyroidism, or as a result of treatment.

STANDARDS:

1. Discuss the significant complications associated with hyperthyroidism (atrial fibrillation, heart failure, angina, myocardial infarction, osteoporosis, depression, personality changes, proptosis).
2. Explain that taking medications as prescribed may prevent most or all significant complications.
3. Discuss common or significant complications which may result from treatment, i.e., subsequent hypothyroidism and the need to take lifelong medication.

HTH-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology of hyperthyroidism.

STANDARDS:

1. Explain that hyperthyroidism occurs when the amount of thyroid hormone in the blood is too high. It affects over 2½ million Americans. More women have this problem than men.
2. Explain that hyperthyroidism leads to an overall increase in a person's metabolism, which can cause a number of problems.
3. Review the patient-specific cause and expected course of hyperthyroidism, i.e., "increased production" due to hypersecretory state (i.e., Grave's disease, toxic nodule, toxic multinodular goiter, or overproduction of TSH from pituitary), "leakage" of stored hormone due to thyroid damage (as in thyroiditis), or too much supplement.
4. Review the symptoms of hyperthyroidism:
    a. feelings of excessive warmth and sweating
    b. palpitations
    c. tremors
    d. weight loss despite having an increased appetite
    e. more frequent bowel movements
    f. weakness
    g. limited endurance
    h. difficulty concentrating
    i. memory impairment
    j. nervousness
    k. tiredness
    l. difficulty sleeping
    m. depression
    n. personality changes
    o. enlarged thyroid—usually nontender.

HTH-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of regular follow-up and will make a plan to obtain and keep appropriate follow-up appointments.

STANDARDS:

1. Discuss the individual's responsibility in the management of hyperthyroidism.
2. Review treatment plan with the patient, emphasizing the need for keeping appointments, fully participating with medication therapy, returning for appropriate follow-up, lab tests, and appointments.
3. Review the symptoms, which should be reported and evaluated (both symptoms of hyperthyroidism and hypothyroidism).
4. Assist the patient in obtaining a follow-up appointment as necessary.

HTH-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about hyperthyroidism.

STANDARDS:

1. Provide the patient/family with written patient information literature on hyperthyroidism.
2. Discuss the content of the patient information literature with the patient/family.

HTH-M MEDICATIONS

OUTCOME: The patient/family will understand the importance of following a prescribed medication regimen.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication.
2. Emphasize the importance of maintaining strict participation in the medication regimen and monitoring schedule.
3. Explain the signs and symptoms of too much or too little medication.
4. Explain the implications that medications have on current or potential pregnancy.
5. Discuss that some medications may have an adverse effect on the disease state, i.e., amiodarone, iodine.

HTH-N NUTRITION

OUTCOME: The patient/family will understand the nutritional needs of the patient with hyperthyroidism.

STANDARDS:

1. Review current nutritional status of patient and the use of dietary supplements.
2. Explain the importance of preventing or treating the complications associated with the patient's high metabolic rate, including bone demineralization.
3. Discuss that supplementation of the diet may be necessary for the following: vitamins A and C, B complex (esp. Thiamin, riboflavin, B6 and B12).
4. Discuss fluid requirements with the patient/family. This should be 3-4 liters per day unless contraindicated by cardiac or renal problems.
5. Discuss the need to avoid alcohol as it may cause hypoglycemia and diuresis.
6. Refer to a registered dietician as appropriate.

HTH-SCR SCREENING

OUTCOME: The patient/family will understand the screening device.

STANDARDS

1. Explain the screening device to be used.
2. Explain why the screening is being performed.
3. Discuss how the results of the screening will be used.
4. Emphasize the importance of follow-up care.

HTH-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed, the risk(s)/benefit(s) of the test(s) and the risk of refusal of the test(s).

STANDARDS:

1. Explain the test ordered (i.e., TSH, T3, T4, nuclear scan, ultrasound).
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment. Discuss the risks of non-performance of the testing.

HTH-TX TREATMENTS

OUTCOME: The patient/family will understand the possible treatments that may be performed based on the test results.

STANDARDS:

1. List the patient-specific possible therapies that might be utilized to treat hyperthyroidism (beta-blocker, anti-thyroid drugs, radioactive iodine, surgery).
2. Briefly explain each of the possible applicable treatments.
3. Explain that the patient and medical team will make the treatment decision after reviewing the results of diagnostic tests.
4. Explain the implications that treatment would have on current or potential pregnancy.

HPTH—Hypothermia

HPTH-C COMPLICATIONS

OUTCOME: The patient/Family will understand common or serious complications of hypothermia.

STANDARDS:

1. Explain that complications depend on how low and how long the body temperature falls.
2. Explain that the lower the core body temperature, the greater the chance of complications and permanent damage.
3. Discuss common and important complications of hypothermia, i.e., arrhythmias, dehydration, hyperkalemia, hyperglycemia, hypoglycemia, altered arterial blood gasses, infection, gangrene, amputation, coma, and frostbite. **Refer to FRST**.
4. Emphasize to seek early medical intervention.

HPTH-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

HPTH-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of hypothermia.

STANDARDS:

1. Explain that body temperature regulation is achieved through precise balancing of heat production, heat conservation, and heat loss.
2. Explain the normal body temperature range is considered to be 36.2° to 37.7°C (96.2° to 99.4° F) but that all parts of the body do not have the same temperature.
3. Explain that a drop in the body's core temperature to 95° F or below is the definition of hypothermia.
4. Discuss that hypothermia usually comes on gradually and people aren't aware they need medical attention.
5. Discuss that common behaviors/signs may be a result of changes in motor coordination and levels of consciousness caused by hypothermia. Some common signs are:
    a. shivering, which is your body's attempt to generate heat through muscle activity
    b. "umbles" — stumbles, mumbles, fumbles and grumbles.
    c. Slurred speech
    d. Abnormally slow rate of breathing
    e. Cold, pale skin
    f. Fatigue, lethargy, or apathy
6. Explain the extremities are generally cooler than the trunk and the body core is generally warmer than the skin surface.
7. Briefly describe hypothermia causes vasoconstriction, alterations in microcirculation, coagulation, and ischemic tissue damage.
8. Explain that environmental conditions, inadequate clothing, and some disease states or conditions may predispose to hypothermia.

HPTH -EQ EQUIPMENT

OUTCOME: The patient/family will understand the indication for the use of equipment.

STANDARDS:

1. Discuss the indications for and benefits of prescribed equipment.
2. Discuss types and features of medical equipment as appropriate.
3. Discuss signs of equipment malfunction and the proper action to take in case of malfunction.

HPTH -FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the prevention of complications.

STANDARDS:

1. Discuss the importance of keeping follow-up appointments.
2. Discuss the procedure for obtaining follow-up appointments.

HPTH -L PATIENT INFORMATION LITERATURE

OUTCOME: The parent(s) and family will receive written information about hypothermia and important preventative measures.

STANDARDS:

1. Provide the patient and/or family with written information about hypothermia.
2. Discuss the content of the patient information literature with the patient and/or family.

HPTH -M MEDICATIONS

OUTCOME: The patient/family will understand the use of medications to manage hypothermia

STANDARDS:

1. Discuss with the patient that complications of hypothermia may require medication therapy.
2. Discuss the importance of taking medication as prescribed.
3. Discuss the common and important side effects and drug interactions of the medications prescribed.

HPTH -N NUTRITION

OUTCOME: The patient/family will understand the importance of adequate nutrition to promote healing.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between making healthy food choices and the healing process.
3. Refer to registered dietician.

HPTH -P PREVENTION

OUTCOME: The patient/family will understand ways to decrease the risk of hypothermia.

STANDARDS

1. Explain that it is easier to prevent hypothermia than to treat it.
2. Discuss risk factors to decrease the risk of hypothermia:
    a. poor or inadequate insulation from the cold or wind
    b. impaired circulation from tight clothing or shoes
    c. fatigue
    d. altitude
    e. wind
    f. immersion
    g. injuries
    h. circulatory disease
    i. poor nutrition
    j. dehydration
    k. alcohol or drug use
    l. tobacco products
    m. extremes of age
3. Discuss ways to decrease risk of hypothermia such as:
    a. Using appropriate layered clothing
    b. avoiding overexertion while outdoors in cold weather
    c. stay dry as much as possible
    d. keep an emergency supply kit in the car which may include blankets, food, matches, candles

HPTH -PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management may be multifaceted. **Refer to PM.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control symptoms of pain.
4. Discuss non-pharmacologic measures that may be helpful with pain control.

HPTH-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in recovery from hypothermia.

STANDARDS:

1. Discuss that uncontrolled stress may increase alcohol and other drug use and interfere with treatment.
2. Emphasize the importance of seeking professional help as needed to reduce stress.
3. Discuss the various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. Becoming aware of your own reactions to stress
    b. Recognizing and accepting your limits
    c. Talking with people you trust about your worries or problems
    d. Setting realistic and meaningful goals
    e. Getting enough sleep
    f. Making healthy food choices
    g. Regular physical activity
    h. Taking vacations
    i. Practicing meditation
    j. Self-hypnosis
    k. Using positive imagery
    l. Practicing relaxation methods such as deep breathing or progressive muscular relaxation
    m. Spiritual or cultural activities.
4. Provide referrals as appropriate

HPTH -TE TESTS

OUTCOME: The patient/family will understand the test to be performed and the reasons for the tests.

STANDARDS:

1. Explain the tests ordered (X-Ray, EKG, urine, blood, ABG's).
2. Explain any necessary preparation prior to tests(s).
3. Explain the indications, risks and benefits of the test(s).
4. Explain the meaning of test results in relation to what "normal" results are.
5. Explain the test as it relates to planning the course of treatment.

HPTH -TX TREATMENT

OUTCOME: The patient/family will understand the management and treatment of hypothermia.

STANDARDS:

1. Discuss the importance of seeking emergency medical care if hypothermia is suspected.
2. Explain if medical attention is not readily available then move the person out of the cold, remove wet clothing, insulate the person's body from the cold ground, monitor breathing, share body heat, and if conscious provide warm nonalcoholic beverages.
3. Discuss what **not** to do if hypothermia is suspected:
   a. Don't apply direct heat
   b. Don't massage or rub the person
   c. Don't provide alcoholic beverages
4. Discuss the importance of slowly increasing the temperature of the person and getting the person into dry clothes when applicable.
5. Discuss the management of hypothermia (i.e., monitoring of vital signs, warming blankets, warm IV fluids, extracorporeal circulation)

LTH—Hypothyroidism

LTH-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the anatomy and physiology of the pituitary-thyroid axis.

STANDARDS:

1. Explain the normal location, function, and feedback mechanism of the pituitary-thyroid axis (heart rate, muscle strength, bowel function, fat metabolism, energy level, hair growth, and mood).
2. Discuss the changes to the thyroid gland and the body's metabolic state as a result of hypothyroidism.
3. Discuss the impact of these changes on the patient's health and well-being.

LTH-C COMPLICATIONS

OUTCOME: The patient/family will understand the effects and consequences possible as a result of hypothyroidism, failure to manage hypothyroidism, or as a result of treatment.

STANDARDS:

1. Discuss the significant complications associated with hypothyroidism (depression, excessive weight gain, high blood pressure, high cholesterol levels).
2. Discuss that full participation with the treatment regimen may prevent most or all significant complications.
3. Discuss common or significant complications which may result from treatment, i.e., jitteriness, heart racing, headaches. Consistently taking medications at the appropriate dose will minimize these complications.

LTH-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology of hypothyroidism.

STANDARDS:

1. Explain that hypothyroidism occurs when the amount of thyroid hormone in the blood is too low. It affects almost 5% of the population. It is more common in women and in elderly persons.
2. Explain that hypothyroidism leads to an overall decrease in a person's metabolism, which can cause a number of problems.
3. Review the patient-specific cause and expected course of hypothyroidism. In most cases hypothyroidism is a permanent condition that requires life-long treatment with natural thyroid supplement.
4. Review the symptoms of hypothyroidism, which include feelings of:
    a. fatigue
    b. lack of motivation
    c. sleepiness
    d. weight gain
    e. feelings of being constantly cold
    f. constipation
    g. dry skin
    h. hair loss
    i. muscle cramps and muscle weakness
    j. high blood pressure and high cholesterol levels
    k. depression
    l. slowed speech
    m. poor memory
    n. feelings of "being in a fog."

LTH-EX EXERCISE

OUTCOME: The patient/family will understand the relationship between physical activity and hypothyroidism and develop a plan to achieve an appropriate level of activity.

STANDARDS:

1. Explain the normal benefits of a regular exercise program to health and well-being.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.
7. Discuss that in hypothyroidism, severe muscle weakness may occur and exercise tolerance is impaired. Explain that exercise is important not only for weight control, but also to reestablish muscle tone and fitness. In general, intense aerobic exercise should only be attempted after thyroid hormone levels have returned to normal. However, the patient can begin walking and modest weight-bearing exercise as treatment is initiated.

LTH-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of making and keeping follow-up appointments and will make a plan to obtain and keep appropriate follow-up appointments.

STANDARDS:

1. Discuss the individual's responsibility in the management of hypothyroidism.
2. Review the treatment plan with the patient, emphasizing the need for keeping appointments, fully participating with medication therapy, returning for appropriate follow-up, lab tests, and appointments.
3. Review the symptoms, which should be reported and evaluated (both symptoms of hyperthyroidism and hypothyroidism).
4. Assist the patient in making follow-up appointments as appropriate.

LTH-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about hypothyroidism.

STANDARDS:

1. Provide the patient/family with written patient information literature on hypothyroidism.
2. Discuss the content of the patient information literature with the patient/family.

LTH-LA LIFESTYLE ADAPTATIONS

OUTCOMES: The patient/family will understand the lifestyle adaptations necessary to maintain optimal health.

STANDARDS:

1. Emphasize that weight gain, high blood pressure, and high cholesterol levels are associated with hypothyroidism.
2. Explain that although most hypothyroid individuals will lose weight after they begin taking a thyroid supplement, significant weight loss will usually require attention to healthy eating habits and exercise. Individuals should avoid setting unrealistic goals.

LTH-M MEDICATIONS

OUTCOME: The patient/family will understand the importance of following a prescribed medication regimen.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication.
2. Emphasize the importance of maintaining full participation in the medication regimen and monitoring schedule.
3. Explain the signs and symptoms of too much or too little medication.
4. Explain the implications that medications have on current or potential pregnancy.
5. Discuss drug/drug and drug/food interactions as appropriate.
6. Discuss that some medications may have an adverse effect on the disease state, i.e., amiodarone, iodine.

LTH-N NUTRITION

OUTCOME: The patient/family will understand the need for balanced nutrition and plan for the implementation of dietary modification.

STANDARDS:

1. Review normal nutritional needs for optimal health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss the need for the correct combination of nutrients and vitamins, as well as the need for a low-fat diet without excessive calories.
4. Explain that the following foods must be limited: cabbage, brussel sprouts, kale, cauliflower, asparagus, broccoli, soy beans, lettuce, peas, spinach, turnip greens and watercress as these foods may increase the risk of developing a goiter.
5. Explain that the long term use of soy protein products may be contraindicated.
6. Encourage the use of iodized salt if indicated.
7. Refer to registered dietician.

LTH-SCR SCREENING

OUTCOME: The patient/family will understand the screening device.

STANDARDS

1. Explain the screening device to be used.
2. Explain why the screening is being performed.
3. Discuss how the results of the screening will be used.
4. Emphasize the importance of follow-up care.

LTH-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Explain the test ordered, i.e., TSH, T3, T4, nuclear scan, ultrasound, blood counts.
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment. Discuss the risks/benefits of non-testing.

I

IM—Immunizations

IM-DEF DEFICIENCY

OUTCOME: The patient/family will understand the importance of fully participating with schedule of prescribed immunizations for protection from vaccine preventable disease.

STANDARDS:

1. Identify reasons for deficiency and provide education as indicated.
2. Explain that deficiency of immunization(s) may cause serious health problems.
3. Discuss diseases that have been eradicated due to immunizations.
4. Discuss the patient's particular immunization deficiency.
5. Review complications that could occur if infection develops.

IM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of receiving immunizations on schedule.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

IM-I IMMUNIZATION INFORMATION

OUTCOME: Patient/family will understand the indication for and benefit of immunization, common and important side effects of vaccination, and post immunization care.

STANDARDS:

1. Explain the indication for immunization including the disease which is to be prevented by immunization.
2. Explain the contraindications of administering the vaccine.
3. Discuss appropriate vaccine sites.
4. Explain the important and common side effects of immunizations to be administered.
5. Explain post-immunization care including dose of antipyretics if needed and what to do if serious side effects are observed.
6. Explain how family members can assist with comforting immunized persons during and after vaccine administration, as culturally appropriate.

IM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about immunizations.

STANDARDS:

1. Provide the patient/family with written patient information literature on immunizations.
2. Discuss the content of the patient information literature with the patient/family.

IM-P PREVENTION

OUTCOME: The patient/family will understand communicability and measures to control vaccine preventable disease for children and adults.

STANDARDS:

1. Explain that vaccines are available against certain infections or diseases.
2. Explain that certain infections can be eliminated or avoided through immunizations.
3. Provide information on types of vaccines available for children and adults.
4. Explain that good hand hygiene, use of tissues and waste receptacles and avoiding touching eyes, nose, and mouth are also important measures in the control of some disease transmission.

IM-SCH SCHEDULE

OUTCOME: The patient/family will understand the importance of fully participating with a schedule of prescribed immunizations for protection from vaccine preventable diseases.

STANDARDS:

1. Explain that some vaccines are prescribed to be given in series, within certain time frames and may not be counted if given too early and may need to be repeated.
2. Explain that some vaccines are required by law.
3. Provide schedules on types of vaccines for children and adults.

IGT—Impaired Glucose Tolerance

Refer to PDM—Prediabetes.

IMP—Impetigo

IMP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the disease process, transmission and causative agent of impetigo.

STANDARDS:

1. Explain that impetigo may be caused by the streptococcus or staphylococcus germs.
2. Explain that impetigo is a skin infection that can spread from one place to another on the body.
3. Explain that impetigo can also spread from person to person.
4. Explain that impetigo may follow superficial trauma with a break in the skin; or the infection may be secondary to pediculosis, scabies, fungal infections, or insect bites.
5. Explain that itching is common and scratching may spread the infection.
6. Describe what to look for:
    a. lesions with a red base and a honey or golden-colored crust or scab
    b. may occur anywhere on the skin, (arms, legs and face are the most susceptible.)
    c. lesions may be itchy
    d. lesions may produce pus.

IMP-FU FOLLOW-UP

OUTCOME: The patient/family will participate in the treatment plan and understand the importance of full participation .

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

IMP-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about impetigo.

STANDARDS:

1. Provide the patient/family with written patient information literature on impetigo.
2. Discuss the content of patient information literature with the patient/family.

IMP-M MEDICATIONS

OUTCOME: The patient/family will verbally summarize their medication regimen and the importance of full participation with therapy.

STANDARDS:

1. Review the proper use, benefits and common side effects of prescribed medications.
2. Explain the importance of completing the full course of antibiotic therapy to prevent antibiotic resistance and to facilitate complete recovery.
3. Explain the importance of adhering to the medication schedule.

IMP-P PREVENTION

OUTCOME: The patient/family will better understand how to prevent skin infections.

STANDARDS:

1. Instruct the patient/family to wash with soap and water every day.
2. Discuss the importance of hand washing in infection control in relation to child care and toilet use. Stress the importance of washing the hands whenever they are dirty.
3. Advise to keep the fingernails cut and clean.
4. Advise to take care of cuts, scratches, and scrapes. Instruct to wash with soap and water.
5. Discourage sharing clothes, towels, toys, dishes, etc. with a person who has impetigo.
6. Explain that certain infections can be dependent upon hygiene, social and/or environmental conditions. **Refer to WL-HY**.
7. Encourage parents/caregivers to wash all toys with soap and water.

IMP-TX TREATMENT

OUTCOME: The patient/family will understand the treatment plan.

STANDARDS:

1. Instruct the patient/family to keep the lesions clean and dry. Washing with an antibacterial soap is beneficial.
2. Instruct to use antibiotic ointment each time after washing, or as ordered.
3. Instruct the patient/family to change and wash clothes, bedding, towels and toys.
4. Discourage scratching sores. Inform the patient/family this can make them worse and cause spreading of the infection.
5. Instruct the patient/family to return to the clinic in 3 to 4 days or as prescribed by physician if the sores are not getting better.
6. Discuss the signs of worsening condition, i.e., increasing redness, soreness, high fever.

FLU—Influenza

FLU-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and important complications of the flu.

STANDARDS:

1. Discuss that one of the most common complications of the flu is pneumonia and may lead to hospitalization.
2. Explain that the flu causes many deaths in the United States every year.
3. Discuss groups who are at higher risk for complications from the flu such as the elderly and infants. Also discuss that persons with chronic diseases such as pulmonary disease, cardiac disease, renal disease, cancer and diabetes are at higher risk for complications from the flu.
4. Discuss the importance of not giving aspirin or products containing aspirin to children (under 16 years of age) with the flu as it may induce a potentially fatal complication of the flu called Reye Syndrome.

FLU-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the basic pathophysiology of influenza infection.

STANDARDS:

1. Discuss that the flu is caused by an influenza virus and that antibiotics are not helpful in treating the flu.
2. Explain that the flu virus changes every year so that having had the flu in a previous year will not necessarily make one immune to flu this year.
3. Discuss that the most common symptoms of the flu are muscle aches, head ache, fever, malaise, non-productive cough, and fatigue.
4. Explain that the flu is spread from person to person by inhalation of small particle aerosols, by direct contact or by contact with objects that have recently been contaminated by secretions from someone who has the flu.

FLU-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss signs and symptoms that would indicate worsening of the disease and prompt a follow-up visit.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize the importance of keeping follow-up appointments.

FLU-IM IMMUNIZATION

OUTCOME: The patient/family will understand the role that immunization plays in preventing influenza. (Discuss the following as appropriate to this patient and situation.)

STANDARDS:

1. Discuss that the vaccine for the flu is formulated for the viruses that are predicted to be most prevalent this year.
2. Discuss that the currently available injected flu vaccines are killed virus vaccines and cannot cause the flu. (Please refer to current information on this year's flu vaccine.)
3. Discuss that there is a live attenuated intranasal vaccine available. This vaccine may protect individuals not only from the flu strains in the vaccine but also other flu strains. It may also decrease the incidence of colds and ear infections.
4. Discuss that persons who have a history of Guillain-Barre Syndrome, egg hypersensitivity or hypersensitivity to any flu vaccine component should probably not get the flu vaccine unless ordered by a physician.
5. Discuss that current injectable flu vaccines are not licensed for use in individuals under the age of 6 months and that the intranasal flu vaccine is licensed for use in individuals between the ages of 5-49 years.
6. Discuss that persons at high risk for complications from influenza are recommended to receive the flu vaccine every year.
7. Discuss the common and important complications of flu vaccine.

FLU-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about influenza.

STANDARDS:

1. Provide the patient/family with written patient information literature on influenza.
2. Discuss the content of the patient information literature with the patient/family.

FLU-M MEDICATIONS

OUTCOME: The patient/family will understand the role of medications used to reduce flu symptoms and/or duration. (discuss the following as appropriate).

STANDARDS:

1. Discuss treatment of symptoms with OTC medications including decongestants, cough suppressants, antipyretics, analgesics, antihistamines.
2. If appropriate, discuss that aspirin should not be used in patients that are under 16 years of age due to risk of Reye's syndrome.
3. Discuss the use of antiviral treatment for influenza and that therapy must be started within 48 hours.
4. Review the proper use, benefits and common side effects of prescribed medications.
5. Explain the importance of completing the full course of antiviral therapy, as prescribed, to prevent antibiotic resistance and to facilitate complete recovery.
6. Explain the importance of adhering to the medication schedule.
7. Discuss that zinc, Echinacea and vitamin C over the counter products for viral infections have not proven to be effective.
8. Explain that antibiotics are not used for viral illnesses because they are not effective on viruses:
    a. Antibiotics used for viral infections can cause antibiotic resistance
    b. Antibiotics can also cause side effects, allergic reactions, and increased cost with no benefit to treating the viral illness.

FLU-N NUTRITION

OUTCOME: The patient/family will understand how nutrition may impact the management of influenza.

STANDARDS:

1. Explain that influenza causes increased fluid losses and that extra fluid intake is usually required.
2. Explain that chicken soup may actually be helpful because it provides extra fluid, potassium and sodium.
3. Explain that small frequent meals or sips of fluid may be better tolerated than larger meals.
4. Discuss that vomiting may be present:
    a. Liquids or food will be better tolerated if the stomach is allowed to "rest" for 30 minutes to one hour before attempts to consume other fluids or foods.
        i. Small frequent intake of fluids will be better tolerated.
        ii. 5 to 15 cc's of clear fluid every 5 to 10 minutes until 8 hours have passed without vomiting is one effective strategy.

FLU-P PREVENTION

OUTCOME: The patient/family will understand communicability and measures to prevent the flu.

STANDARDS:

1. Discuss that influenza is a vaccine preventable disease. **Refer to FLU-IM.**
2. Emphasize the importance of receiving influenza vaccine every year as the virus that causes the flu changes every year.
3. Discuss that careful hand washing can help to prevent the spread of influenza.
4. Discuss that avoiding crowded places can decrease chances of getting influenza.
5. Discuss the importance of covering one's mouth and nose when coughing or sneezing and proper disposal of tissues.
6. Explain that influenza can be spread by fomites (i.e., contaminated objects such as telephone receivers), and that common use of disinfectant cleaners may reduce this spread.

INJ—Injuries

INJ-CC CAST CARE

OUTCOME: The patient/family will understand the treatment plan and then importance of proper cast care.

STANDARDS:

1. Explain the reasons to care appropriately for the cast to improve healing.
2. Emphasize the importance of not placing foreign objects into the cast.
3. Explain the signs or symptoms that would prompt immediate follow-up, i.e., increased swelling, numbness, discoloration, increased pain.
4. Emphasize the importance of follow-up.

INJ-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate (when appropriate) proper use and care of medical equipment.

STANDARDS:

1. Discuss indications for and benefits of prescribed medical equipment to be used during the hospital stay.
2. Discuss and/or demonstrate proper use and care of medical equipment; participate in return demonstration by patient/family.
3. Emphasize safe use of equipment.

INJ-EX EXERCISE

OUTCOME: The patient/family will understand the exercises recommended or restricted as a result of this injury.

STANDARDS:

1. Discuss exercise recommendations or restrictions as they relate to the patient's injury.

INJ-FU FOLLOW-UP

OUTCOME: The patient/family will understand the treatment plan and the importance of making and keeping follow-up appointments.

STANDARDS:

1. Explain the recommended schedule for follow-up.
2. Explain the mechanism for obtaining follow-up.

INJ-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of injuries and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer falls, fewer emergency room visits, fewer hospitalizations and fewer complications.

INJ-I INFORMATION

OUTCOME: The patient/family will understand the pathophysiology of the patient's specific injury and recognize symptoms indicating a worsening of the condition.

STANDARDS:

1. Discuss the patient's specific injury, including anatomy and pathophysiology as appropriate.
2. Discuss the treatment plan and any indicated home management.
3. Discuss signs/symptoms of worsening of the condition and when to seek medical care.

INJ-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about their specific injury.

STANDARDS:

1. Provide the patient/family with written information about the patient's injury.
2. Discuss the content of the patient information literature with the patient/family.

INJ-M MEDICATION

OUTCOME: The patient /family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
2. Emphasize the importance of full participation with medication regimen.
3. Discuss the mechanism of action as needed.
4. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
5. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

INJ-P PREVENTION

OUTCOME: The patient/family will understand mechanisms to prevent occurrence of similar injuries in the future.

STANDARDS:

1. Discuss safety measures which may be implemented to prevent the occurrence of a similar injury in the future.
2. **Refer to WL-S.**

INJ-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Explain non-pharmacologic measures that may be helpful with pain control.

INJ-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

INJ-WC WOUND CARE

OUTCOME: The patient/family will understand the necessity and procedure for proper wound care. As appropriate they will demonstrate the necessary wound care techniques.

STANDARDS:

1. Explain the reasons to care appropriately for the wound, i.e., decreased infection rate, improved healing.
2. Explain the correct procedure for caring for this patient's wound.
3. Explain signs or symptoms that should prompt immediate follow-up; increasing redness, purulent discharge, fever, increased swelling/pain, etc.
4. Detail the supplies necessary for the care of this wound (if any) and how/where they might be obtained.
5. Emphasize the importance of follow-up.

L

LAB—Laboratory

LAB-DRAW PHLEBOTOMY

OUTCOME: The patient/family will understand the phlebotomy procedure.

STANDARDS:

1. Discuss the method of phlebotomy to be used for this lab draw.
2. Discuss common and important side effects or consequences of phlebotomy.

LAB-FU FOLLOW-UP

OUTCOME: The patient/family will understand the conditions that would require follow-up and how to obtain follow-up.

STANDARDS:

1. Discuss the findings that will signify a serious complication or condition.
2. Discuss the procedure for obtaining follow-up appointments.

LAB-L LITERATURE

OUTCOME: The patient/family will receive written information about the disease process or condition.

STANDARDS:

1. Provide patient/family with written patient information on the disease state or condition.
2. Discuss the content of patient information literature with the patient/family.

LAB-S SAFETY

OUTCOME: Explain the procedure used to protect the patient and staff.

STANDARDS:

1. Discuss the use of personal protective equipment (i.e., gloves) and their role in preventing transmission of disease to the patient and the staff.
2. Discuss that needles and other lab draw equipment are single patient use and will be discarded after this draw.
3. Discuss the procedure for accidental needle-stick of the patient or the staff as appropriate.

LAB-TE TESTS

OUTCOME: The patient/family will understand the test to be performed.

STANDARDS:

1. Explain the test that has been ordered.
2. Explain the necessity, benefits, and risks of the test to be performed. Refer to the primary provider as necessary.
3. Explain any necessary preparation for the test, i.e., fasting.
4. Explain the procedure for obtaining test results.
5. If the patient will obtain the specimen explain the procedure for properly obtaining the specimen and the storage of the specimen until it is returned to the lab.

LIV—Liver Disease

LIV – AP ANATOMY AND PHYSIOLOGY

OUTCOME: The Patient/Family will have a basic understanding of where the liver is located in the body and its function.

STANDARDS:

1. Explain that the liver is the largest organ in the abdominal cavity. It is a vital organ responsible for storing, converting, and synthesizing essential nutrients in conjunction to detoxifying drugs and producing clotting factors.
2. Explain that life style practices such as alcohol/substance abuse or exposure to certain toxic materials or viral infections can damage the liver.
3. Explain that the liver has some capacity to regenerate or repair. This ability is inhibited or eliminated by continuous exposure to toxic substances such as alcohol, drugs, infections and other unknown factors.
4. Explain that alcohol and many other foreign substances must be detoxified by the liver in order for the substance to be eliminated from the body.

LIV – C COMPLICATIONS:

OUTCOME: Patient/family will understand the complications of untreated or progressive liver disease (discuss standards that apply to patient's disease process).

STANDARDS:

1. Explain that Ascites, defined as a pathological fluid in the peritoneal cavity, is often seen in patients with hepatic cirrhosis. Review current findings regarding prognosis for patients with Ascites may be poor if not properly managed.
2. Explain that jaundice is a build up of bile acids and bilirubin. It is a yellowish discoloration of the skin, mucus membranes, and some body fluids maybe a sign of a cirrhotic liver.
3. Explain that end stage liver disease may have as a complication intense uncontrollable pruritis.
4. Explain that a common complication of liver disease is esophageal varices. Rupture of one of these varices is a life-threatening complication of liver disease.
5. Discuss that liver disease has a profound impact on clotting factors and may result in uncontrollable bleeding or abnormal clotting which can result in end organ damage of any part of the body.
6. Explain that another common end stage complication of liver disease is encephalopathy which may lead to a comatose state and death.
7. Explain that obesity can contribute to a fatty liver.

LIV-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

LIV – DP DISEASE PROCESS

OUTCOME: The patient/family will understand their specific liver disease. (Discuss the standards that pertain to this patient's liver disease.)

STANDARDS:

1. Explain that cirrhosis is caused by chronic degeneration of the parenchymal liver cells and thickening of the surrounding tissue.
2. Explain that alcohol and some drugs alter both the activation and degradation of key nutrients thereby compromising the overall function of the body.
3. Explain that cryptogenic cirrhosis is caused by unknown etiology.
4. Explain that certain viral infections such as hepatitis may result in destruction of liver cells, cirrhosis or hepatic cancer.
5. Explain that medications and over-the-counter medications and supplements can cause liver damage or liver failure. Larger than recommended dosages of acetaminophen (Tylenol®) can result in irreversible liver damage and death. This effect may be amplified by concurrent use of alcohol.

LIV – FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of fully participating in the treatment regimen and make a plan for appropriate ongoing follow-up.

STANDARDS:

1. Discuss the patient's responsibility in the management of their disease process.
2. Discuss the importance of limiting substances that are toxic to the liver.
3. Emphasize the importance of following the treatment plan even if the patient is asymptotic.
4. Discuss the procedure for obtaining follow-up appointments.
5. Emphasize the importance of keeping follow up appointments.

LIV-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about liver disease.

STANDARDS:

1. Provide and discuss written information about liver disease with the patient/family.

LIV-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will collaborate to make the lifestyle adaptations necessary to minimize complications and improve overall health.

STANDARDS:

1. Review lifestyle/changes that the patient can control such as diet, exercise, medication regimen, safety and injury prevention, avoidance of high risk behaviors and full participation with the treatment plan.
2. Emphasis the importance of the patient's adaptation to a healthier and lower risk lifestyle in order to minimize the complications of liver disease.
3. Review the community resources available to assist the patient in making lifestyle changes and make referrals as needed.

LIV-M MEDICATIONS

OUTCOME: The patient/family will understand the medications prescribed in the management of their disease process.

STANDARDS:

1. Emphasize the importance fully participating in the prescribed medication regimen.
2. Discuss proper use, benefits, common side effects, storage, and common interactions of prescribed medication. Review signs of possible toxicity and appropriate follow-up as indicated.
3. Explain to the patient/family that the patient's physician, pharmacist, provider should be contacted before starting, discontinuing or changing any prescription medications, over-the -counter drugs or dietary/herbal supplements.

LIV-N NUTRITION

OUTCOME: The patient/family will understand the diet regimen pertaining to liver disease.

STANDARDS:

1. Explain that the appropriate dietary regimen is one of the essential components in the management of liver disease.
2. Explain that the patient should meet regularly with a Registered Dietitian for ongoing medical nutrition therapy.
3. Explain that fluid restrictions may be necessary to reduce fluid retention due to portal hypertension.

LIV-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

LIV-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available based on the specific disease process, test results, and individual preferences.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options. Discuss the risks and benefits of treatment as well as the possible consequences of refusing treatment.
2. Discuss the treatment plan including lifestyle adaptations, pharmacologic, surgical, and psychosocial aspects of the treatment plan.
3. Discuss the importance of adhering to the treatment plan, emphasizing the importance of full participation even if the patient is asymptomatic.
4. Emphasize the importance of keeping scheduled follow-up appointments.
5. Refer to community resources as appropriate.

M

DEP—Major Depression

DEP-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

DEP-DP DISEASE PROCESS

OUTCOME: The patient and/or family will understand the psychological and physiological causes of major depression.

STANDARDS:

1. Discuss the common symptoms of major depression with the patient and/or family:
   a. Persistent sadness lasting longer than two weeks
   b. Loss of interest in usual activities
   c. Weight loss or gain
   d. Sleep disturbances
   e. Energy loss
   f. Fatigue
   g. Hyperactive or slowed behavior
   h. Decreased or slowed sexual drive
   i. Feelings of worthlessness
   j. Difficulty concentrating or making decisions
   k. Recurrent suicidal thoughts. **Refer to SB**.
   l. Memory loss
2. Assure the patient and/or family that prognosis is usually good, with appropriate treatment.
3. Stress that many episodes of depression are not preventable. Treatment, including medications and psychiatric intervention, may prevent recurrences.
4. Discuss that antidepressant drug therapy combined with psychotherapy appears to have better results than either therapy alone.

DEP-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in this patient's disease process and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that moderate exercise may increase energy, improve circulation, enhance sleep, and reduce stress and depression.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

DEP-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of treatment plan full participation and regular follow-up.

STANDARDS:

1. Discuss the patient's responsibility in managing major depression.
2. Review the treatment plan with the patient/family, emphasizing the need for keeping appointments and adhering to medication regimens.
3. Instruct the patient/family to contact a mental health professional or other medical personnel if persistent thoughts of suicide occur.
4. Explain the process for making follow-up appointments.

DEP-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about major depression.

STANDARDS:

1. Provide the patient/family with written patient education literature on major depression.
2. Discuss the content of the patient education literature with the patient/family.

DEP-M MEDICATIONS

OUTCOME: The patient/family will understand the proper use of antidepressant medication.

STANDARDS:

1. Review the mechanism of action of the prescribed medication.
2. Discuss proper use, benefits and common side effects of prescribed medications.
3. Explain that some medications may have long-term effects that require regular monitoring and follow-up.
4. Discourage the use of alcohol and recreational drugs.
5. Explain that it may be six weeks before the antidepressant medication takes effect.
6. Explain that drug therapy may include one or a combination of tricyclic antidepressants, monoamine oxidase inhibitors and serotonin re-take uptake blockers or psychotropic medications that work by other mechanisms.
7. Discuss the risks associated with the medications especially in overdoseage. All medications should be stored in a safe place in child-resistant containers.
8. Discuss drug/drug and drug/food interactions as applicable.

DEP-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy.

STANDARDS:

1. Emphasize that for the process of psychotherapy to be effective the patient must keep all appointments.
2. Emphasize the importance of openness and honesty with the therapist.
3. Explain to the patient that the therapist and the patient will establish goals, ground rules, and duration of therapy.

DEP-SCR SCREENING

OUTCOME: The patient/family will understand the screening device.

STANDARDS

1. Explain the screening device to be used.
2. Explain why the screening is being performed.
3. Discuss how the results of the screening will be used.
4. Emphasize the importance of follow-up care.

DEP-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in major depression.

STANDARDS:

1. Explain that uncontrolled stress is linked with the onset of major depression and contributes to more severe symptoms of depression.
2. Explain that uncontrolled stress can interfere with the treatment of major depression.
3. Explain that effective stress management may reduce the severity of symptoms the patient experiences, as well as help improve the health and well-being of the patient.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the severity of the depression and increase risk of suicidal behaviors.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

DEP-WL WELLNESS

OUTCOME: The patient/family will understand some of the factors which contribute to a balanced and healthy lifestyle.

STANDARDS:

1. Explain that a healthy diet is an important component of emotional health.
2. Emphasize the importance of stress reduction and exercise in emotional health.
3. Refer the patient/family to support groups as appropriate.

MSX—Metabolic Syndrome

MSX-C COMPLICATIONS

OUTCOME: The patient will understand the complications associated with metabolic syndrome.

STANDARDS:

1. Explain that metabolic syndrome is a precursor to cardiovascular disease and diabetes.
2. Explain that arteriosclerosis and atherosclerosis impede blood flow through the circulatory system.
3. Explain that heart attacks may result from the heart having to work harder to pump blood through congested and hardened arteries.
4. Explain that good control of blood sugar can reverse or prevent progression of pre-diabetes.
5. Explain that strokes may result due to injured blood vessels in the neck or brain.
6. Explain that blindness may result from injured blood vessels in the eye.
7. Explain that leg pain may result due to injured blood vessels in the legs.

MSX-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

MSX-DP DISEASE PROCESS

OUTCOME: The patient will have a basic understanding of the pathophysiology of the metabolic syndrome.

STANDARDS

1. Explain that metabolic syndrome is a combination of dyslipidemia, hypertension and pre-diabetes (insulin resistance).
2. Review the risk factors and causative factors of dyslipidemia, hypertension and pre-diabetes.
3. .Discuss HDL, non-HDL, LDL and triglycerides. Define normal ranges.
4. Explain the difference between systolic and diastolic pressure. Define normal ranges.
5. Discuss the role of insulin resistance**.** Define normal ranges.

MSX –EQ EQUIPMENT

OUTCOME: The patient will receive information on the use of home blood pressure monitors and pedometers.

STANDARDS:

1. Provide the patient with information on the use of specific home blood pressure monitors and pedometers.
2. Discuss the use of blood pressure monitoring equipment in public places, i.e., such as stores.
3. Discuss correct way to record blood pressure and pedometer activity in a logbook and bring to clinic visits.
4. Discuss when to contact a healthcare provider for a blood pressure value which is outside the patient's personal guidelines.
5. Discuss the proper use and care of medical equipment.
6. Discuss signs of equipment malfunction and proper action in case of malfunction.

MSX-EX EXERCISE

OUTCOMES: The patient will understand the relationship of exercise to normal lipids, blood pressure and blood sugar. The patient will develop a physical activity plan.

STANDARDS:

1. Explain that consistent daily physical activity and improve dyslipidemia, blood pressure, blood sugar.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

MSX-FU FOLLOW-UP

OUTCOMES: The patient will understand the importance of follow-up. The patient will develop a plan to make and keep appointments.

STANDARDS:

1. Emphasize the patient's responsibility in developing and following a treatment plan and keeping follow-up appointments.
2. Discuss the procedure for making appointments.
3. Discuss any necessary preparation for lab test(s).

MSX-L PATIENT INFORMATION LITERATURE

OUTCOMES: The patient will receive written information about metabolic syndrome.

STANDARDS:

1. Provide the patient with written information about metabolic syndrome.
2. Discuss the content of the patient information literature with the patient.

MSX-LA LIFESTYLE ADAPTATIONS

OUTCOMES: The patient will understand the lifestyle adaptations necessary to prevent or delay the progression of metabolic syndrome and develop a realistic plan to accomplish this.

STANDARDS:

1. Emphasize that healthy food choices and regular physical activity are the critical components in improving metabolic syndrome and preventing the progression to diabetes and cardiovascular disease.
2. Discuss the importance of tobacco cessation. Make referral to tobacco cessation programs if available.
3. Discuss the relationship of stress to metabolic syndrome and suggest ways to reduce stress. Refer to stress reduction program as appropriate.
4. Assist the patient to develop a self care plan.

MSX-M MEDICATIONS

OUTCOMES: The patient/family will understand their medication(s), regimen and the importance of fully participating in therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of the prescribed medications.
2. Discuss any drug-drug or drug-food interactions with this medication as appropriate.
3. Review clinical effects and onset of action expected with these medications.
4. Review recommended monitoring laboratory tests which may be ordered.
5. Explain importance of avoiding over-the-counter medications without checking with a physician and/or pharmacist.
6. Discuss common and important signs of toxicity and/or adverse reactions and what to do if the patient/family suspects a reaction.

MSX-N NUTRITION

OUTCOMES: The patient will understand the importance of nutritional management in the improvement of metabolic syndrome.

STANDARDS:

1. Refer to registered dietician as appropriate.
2. Emphasize that nutritional management includes meal planning, making healthy food choices, appropriate serving sizes and food preparation.
3. Review the food pyramid and its role in meal planning.
4. Explain how to read nutrition information labels. Emphasize the importance of noting the serving size – the serving size may not be the same as the container size.
5. Discuss the merits of various food preparation methods.
6. Describe appropriate portion size and emphasize its importance.
7. Discuss the importance of decreasing total fat intake and using healthier fats sparingly.
8. Explain that excessive salt intake may play a role in hypertension and discuss ways to decrease salt intake.

MSX-P PREVENTION

OUTCOME: The patient will understand ways to prevent cardiovascular disease and diabetes.

STANDARDS:

1. Explain that consuming a diet low in fat and cholesterol, controlling weight and exercising may help prevent complications from metabolic syndrome or progression to cardiovascular disease and diabetes.
2. Emphasize the importance of regular blood sugar, blood pressure, and lipid screening. Discuss current recommendations for screening and/or monitoring.
3. Explain that the metabolic syndrome tends to run in families and that the patient's family members should be evaluated by a physician or other health care provider.

MSX-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in metabolic syndrome.

STANDARDS:

1. Explain that uncontrolled stress can cause increased release of stress hormones which can contribute to insulin resistance, dyslipidemia, obesity and hypertension. This can lead to increased morbidity and mortality from all disease processes included in metabolic syndrome.
2. Explain that uncontrolled stress can interfere with the treatment of metabolic syndrome.
3. Explain that effective stress management may reduce the adverse consequences of metabolic syndrome, as well as help improve the health and well-being of the patient.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality from metabolic syndrome.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

MSX-TE TESTS

OUTCOMES: The patient will understand the test(s) to be performed including indications and its impact on further care.

STANDARDS:

1. Explain the test(s) ordered, i.e., FBS , A1C, Lipids.
2. Explain any necessary preparation prior to the test(s).
3. Explain the indications, risks and benefits of the test(s), including risks of not having the test(s) performed.
4. Explain the meaning of the test results in relation to what “normal” results are, as appropriate.
5. Explain the test as it relates to planning the course of treatment.

N

NDR—Near Drowning

NDR-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand the pathophysiology of near drowning.

STANDARDS:

1. Explain that the most important contribution to morbidity and mortality resulting from near drowning is hypoxemia and decrease in oxygen delivery to vital tissues.
2. Explain that the pathophysiology of near drowning is intimately related to the multiorgan effects of hypoxemia.
3. Explain that central nervous system (CNS) damage may occur as a result of hypoxemia sustained during the drowning episode or secondarily because of pulmonary damage and subsequent hypoxemia.
4. Explain that aspiration of fluid and vasoconstriction can result in significantly impaired gas exchange. Explain that acute respiratory distress syndrome (ARDS) may develop as a result of aspiration.
5. Explain that myocardial dysfunction may result from ventricular dysrhythmias and asystole due to hypoxemia. In addition, hypoxemia may directly damage the myocardium, decreasing cardiac output.
6. Explain that metabolic acidosis may impair cardiac function.

NDR-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications resulting from near drowning and how it relates to their specific condition.

STANDARDS:

1. Explain that the following may result from the near drowning experience:
   a. Neurologic injury (c spine or head trauma)
   b. Pulmonary edema or ARDS
   c. Secondary pulmonary infection
   d. Multiple organ system failure
   e. Acute tubular necrosis
   f. Myoglobinuria
   g. Hemoglobinuria
2. Explain that the risk of serious complications may be reduced by seeking prompt medical attention.

NDR-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of treatment and make a plan for appropriate follow-up.

STANDARDS:

1. Discuss the patient/family responsibility in follow-up care.
2. Discuss the individual treatment plan with the patient/family.
3. Discuss the procedure for obtaining follow-up appointments.

NDR-L LITERATURE

OUTCOME: The patient/family will receive written information about near drowning.

STANDARDS:

1. Provide the patient/family with written patient information literature on near drowning.
2. Discuss the content of patient information literature with the patient/family.

NDR-M MEDICATIONS

OUTCOME - The patient/family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
2. Emphasize the importance of full participation with medication regimen.
3. Discuss the mechanism of action as needed.
4. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
5. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

NDR-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of drowning.

STANDARDS:

1. Explain that the key to the prevention of drowning is education.
2. Explain that parents should be aware of their own as well as their children's limitations around water.
3. Instruct patients to never swim alone and always supervise children when swimming.
4. Emphasize the importance of safe conduct around water and during boating and water or jet skiing.
5. Discourage the use of alcohol or recreational drugs while around water.
6. Encourage the use of appropriate boating equipment, (personal flotation devices)
7. Encourage the patient/family to be aware of weather and water conditions prior to boating or swimming.
8. Encourage patient/family members to learn CPR and rescue techniques.
9. Encourage patient/family to check water depth and underwater hazards (i.e., rocks, drop-offs, currents) prior to swimming and diving.
10. Emphasize the importance of providing fencing and locking gates around swimming pools.
11. Explain that the following medical conditions may increase risk for drowning:
    a. Seizure disorders
    b. Diabetes mellitus
    c. Significant coronary artery disease
    d. Severe arthritis
    e. Musculoskeletal disorders

NDR-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Discuss the necessity, benefits and risks of the test to be performed, as appropriate, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Discuss the meaning of the test results, as appropriate.

NF—Neonatal Fever

NF-C COMPLICATIONS

OUTCOME: The parent/family will understand the potential complications of neonatal fever.

STANDARDS:

1. Explain that neonatal fever may be the result of bacterial infection and that this may result in death, neurologic sequella, or physical deformity, as appropriate.
2. Discuss the need to have a neonate with fever evaluated immediately to decrease the risk of these complications.

NF-DP DISEASE PROCESS

OUTCOME: The parent/family will understand the possible etiologies of neonatal fever and why neonatal fever is so potentially devastating.

STANDARDS:

1. Explain that in the first 60 days of life an infant's immune system is not as competent at fighting infection as it is later in life. Explain that neonates are often unable to contain an infection in a certain body system and that the infection can become overwhelming and wide-spread in a very short period of time.
2. Explain that an infection, especially a bacterial infection can be fatal to a neonate.
3. Explain that fever can be a signal of many different things, among them, infections with various bacteria or viruses.
4. Discuss the need to have a neonate with fever evaluated immediately to decrease the risk of complications from neonatal infection.

NF-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

NF-FU FOLLOW-UP

OUTCOME: The parent/family will understand the importance of follow-up care for a neonate who has had fever and the procedure for obtaining follow-up care.

STANDARDS:

1. Explain that it is especially important to follow-up neonatal fever if the fever has been treated by outpatient management and that this follow-up should continue until the physician or provider has declared that the risk from the fever has past.
2. Explain that follow-up of neonatal fever that has been treated as an inpatient is important to assure that the infant has been fully treated and is recovering from the disease process that caused the fever.
3. Explain the process for making follow-up appointments and assist the parent/family as necessary in obtaining follow-up care.

NF-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about neonatal fever.

STANDARDS:

1. Provide patient/family with written patient information literature on the neonatal fever.
2. Discuss the content of patient information literature with the patient/family.

NF-M MEDICATIONS

OUTCOME: The parent/family will understand that the use of antibiotics is necessary in the treatment of neonatal fever until determination has been made that bacterial infection is not the causative agent of the fever.

STANDARDS:

1. Explain that because bacterial infections in neonates can be fatal extra caution is in order and many providers will give antibiotics before the causative agent has been identified. This is done to protect the neonate (with his/her incompletely developed immune system) from the potentially devastating consequences of bacterial infection.
2. Discuss the common and important side effects of the medications to be used.
3. Discuss drug/drug or drug/food interactions as appropriate.

NF-P PREVENTION

OUTCOME: The parent/family will understand that neonatal fever can often be prevented and the measures to take to prevent the neonate from becoming infected.

STANDARDS:

1. Explain that because an infant in the first 60 days of life has a less competent immune system it is important to protect him/her from germs (bacteria/viruses).
2. Explain that bacteria and viruses are usually passed from one human to another.
3. Explain that it is important to keep the neonate out of public places for the first 60 days of life to decrease his/her exposure to other humans. (Public places or any place one can reasonably anticipate seeing more than 4 or 5 people, i.e., such as grocery stores, department stores, ball games, school functions, restaurants.)
4. Explain that hand washing at home is an effective way to prevent the spread of bacteria and viruses in the home.
5. Explain that family members who become ill should avoid contact with the neonate if at all possible. (The possible exception to this being the nursing mother who is providing for the infant, antibodies to her illness through breastmilk.)
6. Explain that breastfeeding improves the neonates immune system by the passing of antibodies to the infant in the mother's milk.

NF-TE TESTS

OUTCOME: The parent/family will understand that testing is necessary to determine the etiology of the fever. They will also have an understanding of the potential adverse outcomes of the tests to be performed or the risks of not performing the recommended tests.

STANDARDS:

1. Discuss with the parent/family the test(s) to be performed. Discuss the procedure for performing the test(s) in terms that can be understood by the parent/family.
2. Explain the benefit of the test as well as the risk(s) involved in performing the test(s). Explain the risk(s) associated with not performing the recommended test(s).
3. Explain that obtaining the results of some tests routinely performed to determine the etiology of neonatal fever (cultures of various body fluids) can take several days.

NJ—Neonatal Jaundice

NJ-C COMPLICATIONS

OUTCOME: The family will understand the common or serious complications of neonatal jaundice.

STANDARDS:

1. Explain that the most common complication of neonatal jaundice is lethargy resulting in decreased feeding followed by increased dehydration and worsening jaundice.
2. Explain that the most serious complication of neonatal jaundice is acute bilirubin encephalopathy and kernicterus.
3. Emphasize the importance of watching for jaundice and seeking medical care if jaundice is noticed to prevent complications.
4. Discuss complications associate with treatment of neonatal jaundice:
    a. Eye damage from phototherapy lights
    b. Dehydration
    c. Blood born pathogens from exchange transfusions
    d. Delay in the bonding process
    e. Complicates breastfeeding

NJ-DP DISEASE PROCESS

OUTCOME: The family will understand the basic pathophysiology of neonatal jaundice.

STANDARDS:

1. Explain that over ½ of newborns develop some degree of jaundice.
2. Explain that neonatal jaundice is characterized by yellow discoloration of the skin and in some cases the whites of the eyes.
3. Explain that the yellow discoloration is caused by a chemical in the blood called bilirubin which is a breakdown product of red blood cells.
4. Discuss that everyone is breaking down red blood cells and producing new ones constantly.
5. Explain that in-utero the bilirubin is broken down by the mother's liver but the most common reason for neonatal jaundice is immaturity of the newborn's liver enzymes which are unable to break down the bilirubin fast enough to prevent jaundice.
6. Discuss other less common reasons for jaundice as appropriate:
    a. Maternal antibodies against the newborn's blood resulting in hemolysis
    b. Extensive bruising or cephalohematoma secondary to the birth process
    c. Dehydration or excessive weight loss after birth
    d. Prematurity
    e. G6PD deficiency resulting in hemolysis
    f. Other hemolytic processes
7. Explain, as appropriate, that some individuals are at higher for development of jaundice:
    a. Persons whose sibling required phototherapy
    b. Infants less than 38 weeks gestation
    c. Breastfed infants, especially when there is difficulty initiating breastfeeding
    d. Macrosomic infants of gestational diabetic mothers
    e. Infants with significant weight loss
    f. Infants born to mothers >25 years of age
    g. Male infants

NJ-P PREVENTION

OUTCOME: The family will understand the measures that may prevent jaundice or complications from jaundice.

STANDARDS:

1. Explain that breastfeeding 8-12 times per day will help to prevent jaundice or significant complications from jaundice.
2. Emphasize the importance of watching for jaundice and seeking medical care if jaundice is noticed to prevent complications.
3. Emphasize that the evaluation of blood bilirubin levels as soon as jaundice is identified can help reduce complications by initiating therapy when indicated.
4. Explain that interventions such as medical phototherapy or exchange transfusions can decrease the incidence of complications such as acute bilirubin encephalopathy and kernicterus.

NJ-TE TESTS

OUTCOME: The family will understand the test(s) to be performed including indications and its impact on further care.

STANDARDS:

1. Explain that there are two ways to test for bilirubin levels:
   a. blood bilirubin levels (more accurate)
   b. Transcutaneous bilirubinometer
2. Emphasize that visual estimation of bilirubin levels leads to errors.
3. Explain that numerous blood draw may be necessary as following levels bilirubin levels and other lab tests closely is necessary to avoid complications.

NJ-TX TREATMENT

OUTCOME: The family will understand the treatment plan.

STANDARDS:

1. Discuss that exposing the infants to sunlight is no longer recommended to lower bilirubin levels due to the risks of exposure.
2. Explain that medical phototherapy lowers bilirubin levels by breaking down bilirubin through the skin.
3. Explain that exchange transfusion may be necessary for dangerously high bilirubin levels or if acute bilirubin encephalopathy is identified.

O

OBS—Obesity

OBS-C COMPLICATIONS

OUTCOME: The patient will be able to name at least 2 complications of obesity.

STANDARDS:

1. Emphasize that obesity is the single most important risk factor in Diabetes Mellitus Type 2.
2. Explain how obesity increases the risk for heart disease, infertility, cholelithiasis, musculoskeletal problems, and surgical complications.

OBS-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

OBS-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the process underlying obesity and will be able to relate this process to changes necessary to attain improved health.

STANDARDS:

1. Relate obesity to health outcomes.
2. Emphasize the relationship among obesity, caloric intake, and exercise.
3. Explain that some people have a genetic predisposition to obesity which will require increased persistence to maintain health.

OBS-EX EXERCISE

OUTCOME: The patient will understand the relationship of physical activity in maintaining a healthy body weight, and will strive to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Stress the fact that exercise is a must in any weight loss program.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

OBS-FU FOLLOW-UP

OUTCOME: The patient will understand that improved health requires a lifelong commitment to lifestyle adaptations which will assist with control of obesity.

STANDARDS:

1. Discuss the individual's responsibility in the management of obesity.
2. Review the patient's plan for lifestyle modification, emphasizing the need for keeping appointments, adhering to dietary modifications and increasing activity levels.
3. Encourage regular weight and blood pressure checks.
4. Reassess exercise and activity levels every 3-6 months.

OBS-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about obesity.

STANDARDS:

1. Provide the patient/family with written patient information literature on obesity.
2. Discuss the content of the patient information literature with the patient/family.

OBS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the importance of making lifestyle adaptations to attain a healthier body habitus.

STANDARDS:

1. Review dietary modifications and restrictions. Refer to the standards for **OBS-N**.
2. Emphasize the benefits of regular exercise. **Refer to WL-EX.**
3. Discuss the importance of good hygiene since additional body fat increases perspiration.
4. Discuss the pros and cons of alternate weight loss options, i.e., fad diets, surgery, medications.

OBS-M MEDICATION

OUTCOME: The patient/family will understand that weight loss medications can have side effects or drug interactions and the importance of discussing any over-the-counter or prescription weight loss medications with the health care provider prior to initiating said medication(s).

STANDARDS:

1. Explain the potentially serious adverse effects of the specific interactions of the medication with other drugs (including OTC medications and traditional or herbal medicines).
2. Specifically discuss adverse effects of this medication when combined with specific foods.
3. Emphasize the importance of informing the provider (i.e., physician, pharmacist, nurse) of any drug interaction(s) that have occurred in the past.
4. Discuss the risk/benefit ratio of the medication(s) that are being considered.

OBS-N NUTRITION

OUTCOME: The patient will identify dysfunctional eating patterns and plan adaptations in eating which will promote weight loss and improved health.

STANDARDS:

1. Assess current eating patterns. Identify helpful and harmful components of the patient's diet.
2. Emphasize the importance of regular meal times and of eliminating snack foods, fatty foods, fatty red meats, reducing sodium consumption and adding more fresh fruits, fresh vegetables and fiber to the diet.
3. Emphasize the necessary component — water — in a healthy diet. Reduce the use of colas, coffee, and alcohol.
4. Review which community resources exist to assist with diet modification and weight control. Refer to dietitian as appropriate.
5. Anticipate psychological or social stressors which may lead to over-consumption. Teach the patient to splurge by plan, not by impulse.
6. Teach person(s) responsible for food purchase and preparation techniques for avoiding fats and simple carbohydrates in meal plans.

OBS-P PREVENTION

OUTCOME: The patient/family will understand the importance of attaining and maintaining a healthy body weight throughout the life span.

STANDARDS:

1. Emphasize that obesity often begins at conception. Discuss the roles of maternal obesity, gestational diabetes, and overfeeding of infants.
2. Encourage a physically active lifestyle. **Refer to WL-EX**.
3. **Refer to WL-N and OBS-C.**
4. Identify cultural, familial, and personal perceptions of body image and their relationship to obesity and health.

OBS-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in obesity.

STANDARDS:

1. Explain that uncontrolled stress is linked with an increased incidence of obesity, which increases the patient's risk of cardiovascular disease, diabetes mellitus, stroke, etc.
2. Explain that uncontrolled stress can interfere with the treatment of obesity.
3. Explain that effective stress management may reduce the complications associated with obesity, as well as help improve the patient's self esteem, health, and well-being.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all of which can increase the risk of morbidity and mortality from obesity.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

OBS-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

ORTH—Orthopedics

ORTH-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient and/or family will have a basic understanding of the anatomy and physiology as it relates to the disease state or condition.

STANDARDS:

1. Explain the normal anatomy and physiology of the body part affected.
2. Discuss the changes to the anatomy and physiology as a result of this condition and/or injury as applicable.
3. Discuss the impact of these changes on the patient's health, well-being and/or mobility.

ORTH-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of orthopedic conditions and/or procedures.

STANDARDS:

1. Explain that failure to fully participate in the prescribed therapy may result in a deficit in function of the limb or body part involved.
2. Discuss common and important complications associated with this illness, injury or condition.

ORTH-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the current knowledge regarding the patient's orthopedic condition and symptoms.

STANDARDS:

1. Explain that an orthopedic condition involves the bones and/or joints. Describe the specific condition.
2. Discuss the current information regarding causative factors and pathophysiology of this disease state/condition.
3. Discuss the signs/symptoms and usual progression of this disease state/condition.
4. Discuss the signs/symptoms of exacerbation/worsening of this disease state/condition.

ORTH-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate, when appropriate, the proper use and care of orthopedic equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss the types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use and care/cleaning of the medical equipment prescribed.
4. Participate in a return demonstration by the patient/family as appropriate.
5. Discuss signs of equipment malfunction and proper action to take in case of malfunction, as appropriate. Provide contact information as appropriate.
6. Emphasize the safe use of medical equipment.
7. Discuss the proper disposal of associated medical supplies.

ORTH-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of regular follow-up and will develop a plan to manage the orthopedic condition and keep follow-up appointments.

STANDARDS:

1. Emphasize that fully participating in the treatment plan is the responsibility of the patient.
2. Review the treatment plan with the patient/family, emphasizing the need for keeping appointments, fully participating with the medication and physical therapy plan.
3. Review the symptoms which should be reported and measures to take if they occur.
4. Stress the importance of keeping follow-up appointments and continuing the therapy for its prescribed duration.

ORTH-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information regarding the specific type of orthopedic condition/injury and its treatment.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding the specific type of orthopedic condition/injury and its treatment.
2. Discuss the content of the patient information literature with the patient/family.

ORTH-M MEDICATIONS

OUTCOME: The patient will understand the importance of their prescribed medications and fully participating in the medication treatment plan.

STANDARDS:

1. Discuss the proper use, benefits, common side effects, and common interactions of the prescribed medications. Review signs of possible toxicity and appropriate follow up as indicated.
2. Emphasize the importance of fully participating in the medication plan.
3. Discuss the mechanism of action of the medication as needed.
4. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
5. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

ORTH-N NUTRITION

OUTCOME: The patient/family will understand the role dietary modification plays in treating orthopedic conditions/injuries and develop an appropriate plan for the necessary dietary modifications.

STANDARDS:

1. Explain that diet can be a contributing factor in the disease process.
2. Explain that diet alone cannot usually treat orthopedic conditions.
3. Encourage the patient to include foods rich in calcium, such as dairy products.
4. Refer to registered dietician as appropriate.

ORTH-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management and the importance of fully participating in the plan.

STANDARDS:

1. Explain that pain management is specific to the disease process/injury of this particular diagnosis and management may be multifaceted.
2. Explain the role of narcotics and other medications in pain management as appropriate.
3. Explain the use of heat and/or cold in the relief of pain as appropriate.
4. Explain that the use of non-pharmacologic measures (i.e., such as physical therapy, imagery, TENS units) in the control of pain.
5. Discuss the importance of restricting the use of the affected body part as recommended by the provider as a pain management tool.

ORTH-PT PHYSICAL THERAPY

OUTCOME: The patient/family will understand the importance of regular physical therapy and will develop a plan to keep physical therapy appointments and fully participate in the physical therapy plan.

STANDARDS:

1. Review the current information regarding the physical therapy indicated for this condition/injury.
2. Explain the benefits, risks and alternatives to the physical therapy plan.
3. Assist the patient/family with a physical therapy plan indicated for this condition/injury. Explain that this may include visits with the physical therapist as well as home exercises.
4. Emphasize that it is the responsibility of the patient to follow the plan.

ORTH-P PREVENTION

OUTCOME: The patient/family will understand that healthy lifestyle behaviors can reduce the risk of developing diseases, conditions, injuries and complication.

STANDARDS:

1. List lifestyle habits that increase the risk for the onset, progression, or spread of the specific orthopedic condition or predispose to injury.
2. Identify behaviors that reduce the risk for the onset, progression, or spread of the specific orthopedic condition or predispose to injury.
3. Assist the patient in developing a plan for prevention of orthopedic conditions and/or injuries.

ORTH-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure(s), as well as the risks, benefits, alternatives to the proposed procedure(s) and associated factors affecting the patient.

STANDARDS:

1. Explain the specific procedure(s) to be performed, including the risks and benefits of performing the procedure and the adverse events which might result from refusal of the procedure.
2. Discuss alternatives to the proposed procedure(s), including expectant management, as appropriate.
3. Discuss the expected patient/family involvement in the care required following the proposed procedure(s).

ORTH-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand the principles of injury prevention and plan a safe environment.

STANDARDS:

1. Explain that injuries are a major cause of death.
2. Discuss the regular use of seat belts and children's car seats and obeying the speed limit.
3. Explain that the use of alcohol and/or drugs increases the risk of injury or death, especially when used by someone operating a motor vehicle or other equipment.
4. Assist the family in identifying ways to adapt the home to improve safety and prevent injuries, as appropriate.
5. Discuss injury prevention adaptations appropriate to the patient's age, disease state, or condition.
6. Identify which community resources promote safety and injury prevention and refer as appropriate.

ORTH-TE TESTS

OUTCOME: The patient/family will understand the planned tests that may be performed, including indications and impact on further care.

STANDARDS:

1. Explain the specific test ordered.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
3. Explain any necessary preparation for the test ordered.
4. Explain the meaning of the test results, as appropriate.

ORTH-TX TREATMENTS

OUTCOME: The patient/family will understand the treatment options that may be used to treat the specific condition or injury.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options.
2. Discuss the treatment plan, including lifestyle adaptations, pharmacologic, surgical, and psychosocial aspects of the treatment plan.
3. Discuss the importance of fully participating in the treatment plan, including scheduled follow-up and physical therapy.

ORTH-WC WOUND CARE

OUTCOME: The patient/family will understand the importance of wound care and demonstrate how to perform appropriate wound care as applicable.

STANDARDS:

1. Explain the risks and benefits of appropriate wound care and how it relates to the specific condition.
2. Explain step by step how wound care is to be performed. Observe return demonstration as appropriate.
3. Discuss the importance of aseptic technique and appropriate wound care in preventing infection.
4. As appropriate, discuss the proper disposal of soiled wound care items.

OM—Otitis Media

OM-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of OM.

STANDARDS:

1. Discuss the effects of chronic OM and/or chronic middle ear fluid, including the possibility of permanent hearing loss.
2. Discuss tympanic membrane perforation as a complication of OM.
3. Discuss the possibility of mastoiditis, as appropriate. Explain that this is extremely rare.

OM-DP DISEASE PROCESS

OUTCOME: The patient/family will better understand the causes and effects of otitis media.

STANDARDS:

1. Explain the anatomy of the middle ear.
2. Explain the pathophysiology of otitis media.
3. Discuss the myths and facts about otitis media, i.e., things that do and do not cause OM.
4. Explain the long-term effects of chronic OM as appropriate.

OM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of OM.

STANDARDS:

1. Discuss the importance of assessing the effectiveness of therapy as it relates to prevention of complications of OM.
2. Emphasize that the only way to assess the effectiveness of therapy is to have the ears re-examined.

OM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about otitis media.

STANDARDS:

1. Provide the patient/family with written patient information literature on otitis media.
2. Discuss the content of the patient information literature with the patient/family.

OM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand how changes in lifestyle can impact OM.

STANDARDS:

1. Discuss the importance of assessing the effectiveness of therapy as it relates to prevention of complications of OM.
2. Explain the negative effect of passive smoking. Discourage smoking in the home and car.
3. Explain that drinking from a bottle, especially in a supine position increases the likelihood of developing OM. Encourage weaning from the bottle at one year of age. **Refer to CHT-W.**

OM-M MEDICATIONS

OUTCOME: The patient/ family will understand the use of medications in OM.

STANDARDS:

1. Discuss the use, benefits and common side effects of the prescribed medication.
2. Discuss the importance of completing the course of antibiotics (to eradicate the infection and reduce the likelihood of emergence of resistant organisms).
3. Discuss the indications for and use of chronic suppressive antibiotics as appropriate.
4. Discuss the use of analgesia in pain control. **Refer to OM-PM.**

OM-P PREVENTION

OUTCOME: The patient/family will understand some ways to decrease recurrence of OM.

STANDARDS:

1. Discuss that breastfeeding decreases the incidence of OM by passage of maternal antibodies in breastmilk.
2. Discuss that exposure to cigarette smoke increases the probability of OM. Encourage parents and other caregivers to never smoke in a home or car where a child will be.
3. Discourage bottle propping or feeding the infant from a bottle in the supine position as this increases the likelihood of developing OM. Encourage weaning from the bottle at one year of age. Refer to CHT-W.

OM-PET PRESSURE EQUALIZATION TUBES

OUTCOME: The patient/family will understand the purpose and important complications of pressure equalization tubes.

STANDARDS:

1. Discuss what PET are and how they work.
2. Discuss the common and important complications of surgery and anesthesia. **Refer to ANS and SPE.**
3. Discuss the 1% chance of chronic tympanic membrane perforation after PET placement.
4. Discuss the importance of protecting the ears from water after PET placement.

OM-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications (such as acetaminophen or non-steroidal anti-inflammatory) may be helpful to control the symptoms of pain.
4. Discuss non-pharmacologic measures that may be helpful with pain control, i.e., warm packs.

OM-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.

P

PM—Pain Management

PM-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand that the perception of pain is highly complex and individualized.

STANDARDS:

1. Explain that pain normally acts as the body's warning signal of tissue injury. This warning signal notifies the body to withdraw from the stimulus.
2. Discuss the difference between the body's physiological response to pain and the person's perception of the event.
3. Explain that tissue damage causes the release of chemicals which result in the sensation of pain. Most pain medications work by blocking these chemicals.
4. Explain that touch type signals (i.e., rubbing, stroking, touching) may block the brain's reception of pain signals.

PM-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient’s condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PM-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pain symptoms, type (i.e., chronic, acute, malignant) and the causes of the patient's pain if known.

STANDARDS:

1. Explain that the patient is the primary source of information about the pain's location, quality, intensity, onset, precipitating or aggravating factors and the measures that bring relief.
2. Emphasize the importance of communicating information about the pain to the provider.
3. Discuss that the patient's presentation of symptoms is a unique combination of the type of pain, individual experiences and sociocultural adaptive responses.
4. Explain that pain tolerance varies greatly from person to person and in the same individual under different circumstances.
5. Explain that it is very rare for patients to become addicted to drugs administered for the relief of acute pain.

PM-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient’s status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

PM-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in this patient's disease process and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that moderate exercise may increase energy, improve circulation, enhance sleep, and reduce stress and depression, and relieve some types of pain.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

PM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

PM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the patient's specific disease process, pain management issues, support groups or community resources as appropriate.

STANDARDS:

1. Provide patient/family with written patient information literature.
2. Discuss the content of the patient information literature with the patient/family.

PM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle changes necessary to optimize performance of everyday activities and promote healing.

STANDARDS:

1. Explain that treatment of pain is very individualized, i.e., medication, rest, exercise, and disease-specific treatment modalities.
2. Explain that exercise and social involvement (i.e., familial, traditional, cultural) may decrease the subjective sense of pain and the depression and anger often associated with pain.
3. Review lifestyle areas that may require adaptations (i.e., diet, physical activity, sexual activity, bladder/bowel habits, role changes, communication skills and interpersonal relationships). Discuss lifestyle changes in relation to disease progression. Review activity limitation as appropriate.
4. Discuss techniques that may reduce stress and depression such as meditation and biofeedback as appropriate.
5. Refer to community resources as appropriate**. Refer to WL**.

PM-M MEDICATION

OUTCOME: The patient/family will verbally summarize the medication regimen and the importance of full participation with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications.
2. Emphasize that excess sedation and euphoria are not goals of palliative pharmacologic therapy.
3. Explain that chronic pain is usually irreversible and often progressive.
4. Discuss patient/family concerns about addiction. Explain the difference between psychological addiction and physical dependence upon prescribed pain medications. Reinforce that addiction is psychological dependence on a drug; and is not equivalent to tolerance or physical dependence.
5. Explain that insomnia and depression are often significant problems for chronic pain patients. Emphasize the importance of developing a plan with the provider to address these issues as appropriate.
6. Explain that spiritual pain is a reality and cannot be relieved with medications.
7. Discuss the importance of full participation with the medication regimen in order to assure optimal comfort levels. For example, round-the-clock dosing of pain medication is more effective in the treatment of chronic pain than medications that are taken after the pain recurs.
8. Discuss the use of adjunctive medication, if indicated, to control analgesic side effects, i.e., anti-emetics, laxatives, antacids.
9. **Refer to M.**

PM-N NUTRITION

OUTCOME: The patient/family will understand the importance of a nutritionally balanced diet in the treatment of their pain and specific disease process. They will be able to identify foods and meal plans that will promote the healing process if applicable.

STANDARDS:

1. Assess current nutritional habits and needs.
2. Emphasize the necessary component - WATER - in a healthy diet.
3. Explain that constipation is a common side-effect of opiates. Dietary measures such as increased water, increased fiber, increased fruit juices and decreased intake of milk products may be helpful. Other control measures should be discussed with the provider prior to initiation.
4. Review the patient's prescribed diet, if applicable. Refer to dietitian or other local resources as indicated.

PM-P PREVENTION

OUTCOME: The patient and/or family will understand the source of pain in relation to the appropriate disease process. They will make a plan to avoid the precipitating factors, minimize disease progression, promote healing; and/or maximize coping strategies.

STANDARDS:

1. Discuss importance of fully participating in treatment plan for an acute injury to reduce the risk of residual chronic pain.
2. Discuss good body mechanics in order to reduce risk of musculoskeletal injuries.

PM-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand that grief reactions are common with chronic pain and that depression may be seen and that treatments are available for these problems.

STANDARDS:

1. Discuss symptoms of grief reaction, i.e., vigilance, trouble concentrating, hyperattentiveness, insomnia, distractibility.
2. Explain that the patient/family may need additional support, sympathy, time, attention, compassion and communication.
3. Explain that if anti-depressant drugs are prescribed by the provider, full participation with the treatment regimen is important to maximize the effectiveness of the treatment.
4. Refer to community resources as appropriate, i.e., bio-feedback, yoga, healing touch, herbal medicine, laughter, humor, traditional healer, guided imagery, massage, acupuncture, acupressure.
5. Explain that many mechanisms for dealing with grief and depression are available, i.e., support groups, individual therapy, family counseling, spiritual counseling. Refer as appropriate.

PM-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Explain the test ordered, i.e., EMG, CT scan, ultrasound.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
3. Discuss any necessary preparation for the test(s).

PM-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available based on the specific disease process, test results, and individual preferences.

STANDARDS:

1. Discuss with the patient/family the possible appropriate noninvasive pain relief measures, i.e., TENS units, heat, cold, massage.
2. Discuss with the patient/family the possible alternative pain relief measures, when appropriate, i.e., meditation, imagery, acupuncture, healing touch, traditional healer, hypnosis.
3. Discuss with the patient/family the possible appropriate pharmacologic pain relief measures. **Refer to PM-M**.
4. Discuss with the patient/family the possible appropriate procedural or operative pain management techniques, i.e., nerve block, intrathecal narcotics, local anesthesia.
5. Emphasize the importance of the patient/family's active involvement in the development of a treatment plan.

PC—Pancreatitis

PC-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PC-DP DISEASE PROCESS

OUTCOME: The patient will understand the causes and symptoms of pancreatitis.

STANDARDS:

1. Explain that pancreatitis is an inflammation of the pancreas caused by activation of digestion enzymes produced by the pancreas.
2. Review the signs of pancreatitis, i.e., steady, boring pain radiating to the back or shoulder; low-grade fever; bulky, pale, foul-smelling stools; nausea and/or vomiting; abdominal distention, jaundice.
3. Relate some common causes, i.e., alcohol ingestion, biliary tract disease, postoperative, post-trauma, metabolic conditions, infections, drug-associated, connective tissue disorders with vasculitis.

PC-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of fully participating in treatment regimen and make a plan for appropriate follow-up.

STANDARDS:

1. Discuss the individual's responsibility in the management of pancreatitis.
2. Review the treatment plan with the patient, emphasizing the need for keeping appointments and adhering to dietary modifications.
3. Emphasize the importance of regular medical follow-up and keeping clinic appointments.
4. Encourage participation in a self-help group, such as AA, if appropriate.

PC-L LITERATURE

OUTCOME: The patient/family will receive written information about pancreatitis.

STANDARDS:

1. Provide the patient/family with written patient information literature on pancreatitis.
2. Discuss the content of patient information literature with the patient/family.

PC-M MEDICATIONS

OUTCOME: The patient will understand the type of medication being prescribed, dosage and administration of the medication. They will also be aware of the proper storage of the medication and possible side effects of the drugs.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication.
2. Emphasize the importance of maintaining full participation in the medication regimen and monitoring schedule.
3. Instruct patient on proper administration of the drug.

PC-N NUTRITION

OUTCOME: The patient will understand ways to minimize future episodes of pancreatitis through nutritional modifications.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between alcohol and pancreatitis.
3. Emphasize the importance of total abstinence from alcohol.
4. Encourage the patient to eat frequent, small meals that are bland and low fat.
5. Encourage the patient to avoid coffee.
6. Assist the patient to develop an appropriate diet plan.
7. Instruct that in many cases a regular diet may be very gradually resumed.
8. Refer to registered dietician as appropriate.

PC-P PREVENTION

OUTCOME: The patient will be able to identify factors related to pancreatitis and, if appropriate, have a plan to prevent future episodes.

STANDARDS:

1. Explain that the major cause of pancreatitis in the US is alcohol ingestion.
2. Explain that if alcohol ingestion was a factor, that complete abstinence from alcohol will decrease the chance of future pancreatitis.
3. Explain that, in some cases, dietary changes may prevent attacks or reduce their severity.

PC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management in gallbladder disease is specific to the disease process of this particular patient and may be multifaceted.
2. Explain that often antispasmodics may be helpful.
3. Explain that short term use of narcotics may be helpful in pain management.
4. Explain that other medications may be helpful to control the symptoms of nausea and vomiting.
5. Explain that administration of fluids may help with pain relief and resolution of symptoms.
6. **Refer to PM**.

PC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

PC-TX TREATMENT

OUTCOME: The patient will understand the treatment plan.

STANDARDS:

1. Explain that pancreatic secretions can be minimized by eliminating oral ingestion of food and fluid. This must be done to "rest" the pancreas.
2. Explain the proper use of pain medications. **Refer to PM.**
3. Explain that, if the pancreatitis episode is prolonged, total parenteral nutrition may be required to maintain nutrition and promote healing.
4. Refer to community resources as appropriate.

PNL—Perinatal Loss

PNL-C COMPLICATIONS

OUTCOME: Patients will know that the most serious complications of perinatal loss are infection, hemorrhage, and possible decrease in fertility.

STANDARDS:

1. Instruct patient on the signs and symptoms of postpartum complications, i.e., hemorrhage, infections, and the possibility of decreased fertility.
2. Explain that a common complication of perinatal loss is depression and that this is usually treatable.
3. Explain that marital difficulties are common after perinatal loss. Encourage open discussion and family counseling or support groups as appropriate.

PNL-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PNL-DP DISEASE PROCESS

OUTCOME: The patient and significant others(s) will understand the type of perinatal loss they had, i.e., miscarriage, ectopic pregnancy, intrauterine death or stillbirth.

STANDARDS:

1. Explain that perinatal loss is common and is most often not a result of actions or lack of actions of the mother.
2. Explain to the patient and significant others what type of perinatal loss the patient had, i.e., miscarriage, stillbirth.
3. Explain to the patient and significant others what the course of the medical treatment will be, i.e., incomplete miscarriage, dilation and curettage, stillbirth induction of labor and vaginal delivery.
4. If appropriate, explain the cause for perinatal loss if one can be identified.
5. If possible explain the implications of this loss on future pregnancies.

PNL-FU FOLLOW UP

OUTCOME: Patient/family will understand the treatment plan and the importance of making and keeping follow-up appointments.

STANDARDS:

1. Instruct patient/family when to return for follow up visits.
2. Instruct patient/family to call or return immediately to the hospital or clinic for any signs of complication.
3. Refer for family planning as appropriate.

PNL-GP GRIEVING PROCESS

OUTCOME: The patient and significant other(s) will understand the grieving process, signs, and symptoms as it pertains to miscarriage, ectopic pregnancy, stillbirth or neonatal death.

STANDARDS:

1. Discuss that culture plays an important role in the grieving process. (Before any teaching/counseling is initiated a discussion with the patient and significant other(s) will be done to ascertain any cultural beliefs and or taboos associated with death and the grieving process. Cultural preferences should be honored.)
2. Explain that grief is a personal process and patients and significant others(s) may have different reactions to the loss. Offer grief information and different options to assist their grieving process.
3. Discuss the grieving process as it relates to perinatal loss.
4. Explain that it is normal to grieve over the loss of the baby, and that everyone may grieve differently, and that different reactions are normal.
5. Explain that anniversary reactions, increased grief during trigger events (i.e., pregnancy of a friend or family member, holidays) are normal.
6. Discuss the various options available to help with the grieving process.
7. As appropriate, encourage viewing of the infant/fetus, picture taking and naming of the infant/fetus.

PNL-L LITERATURE

OUTCOME: The patient/family will receive written patient information literature on perinatal loss and/or related issues.

STANDARDS:

1. Provide the patient/family with written patient information literature on perinatal loss and/or related issues.
2. Discuss the content of the patient information literature with the patient/family.

PNL-M MEDICATIONS

OUTCOME: Patient/family will understand her medication regimen.

STANDARDS:

1. Instruct patient on her discharge medication(s) and the indications and length of therapy for the medication(s).
2. Review the proper use, benefits and common side effects of the medication(s).
3. Emphasize the importance of maintaining full participation in the medication regimen.
4. Discuss common and important drug interactions with foods, drugs and over the counter medications.
5. Encourage continued use of prenatal vitamins as appropriate.

PNL-N NUTRITION

OUTCOME: Patient will understand the need for a balanced diet or special diet as indicated by her medical condition.

STANDARDS:

1. Instruct patient on diet prior to discharge.
2. Encourage patient to continue taking prenatal vitamins or multi vitamin with folic acid.
3. Refer as appropriate to registered dietician or other resources as available.

PNL-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the pain management plan.

STANDARDS:

1. Discuss pain relieving and/or pain management techniques.
2. Patient will be instructed on pain medication available to her and encourage to ask for the medication as needed to relieve her pain.
3. Discuss that pain associated with perinatal loss can be physical, emotional and spiritual. Different techniques may be required to address each type of pain.
4. Discuss non-pharmacologic, traditional or spiritual techniques to address emotional and spiritual needs.

PNL-SM STRESS MANAGEMENT

OUTCOMES: The family member will understand the role of stress management in perinatal loss.

STANDARDS:

1. Explain that perinatal loss may lead to uncontrolled stress, which can contribute to physical illness, emotional distress, and early mortality of the family member.
2. Explain that effective stress management may enable the family member to deal with their loss, as well as help improve their health and well-being.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of depression or suicidal behaviors.
4. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
5. Provide referrals as appropriate.

PNL-TX TREATMENT

OUTCOME: The patient/family will understand the treatment necessary as a result of the perinatal loss if any.

STANDARDS:

1. Explain to the patient and significant others the course of the medical treatment, i.e., dilation and curettage, induction of labor and vaginal delivery, laparoscopy or open abdominal surgery.
2. Discuss issues related to sexual activity and family planning, as appropriate.

PNM—Pneumonia

PNM-C COMPLICATIONS

OUTCOME: The patient will be able to relate the possible complications, the symptoms that should be reported, and the appropriate actions to prevent complications.

STANDARDS:

1. Discuss the possible complications, e.g. pleural effusion, sustained hypotension and shock, other infections such as bacteremia, and atelectasis due to mucus plugs.
2. Explain that complications may be prevented with prompt treatment with appropriate antibiotics and therapy.
3. Advise patient/family to return if cough, fever or shortness of breath worsen or do not improve.

PNM-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PNM-DP DISEASE PROCESS

OUTCOME: The patient will understand pneumonia and its symptoms.

STANDARDS:

1. Explain that pneumonia is an inflammatory process, involving-the terminal airways and alveoli of the lung and is caused by infectious agents.
2. Explain that pneumonia may be contracted by aspiration of oropharyngeal contents, by inhalation of respiratory secretions from infected individuals, through the bloodstream, or directly during surgery or trauma.
3. Explain that patients with bacterial pneumonia may have had an underlying disease that impairs the defenses, such as a preceding viral illness.
4. Explain that weakness and fatigue may persist for weeks after the infection. Encourage a gradual return to normal activities.

PMN-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

PNM-EX EXERCISE

OUTCOME: The patient will be able to demonstrate appropriate deep breathing and coughing exercises.

STANDARDS:

1. Instruct patient in deep breathing, exercises.
2. Instruct patient in techniques to cough effectively.

PNM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

PNM-IS INCENTIVE SPIROMETRY

OUTCOME: The patient will understand the reason for use incentive spirometer and demonstrate appropriate use.

STANDARDS:

1. Explain that regular and appropriate use of the incentive spirometer according to instructions reduces the risk of respiratory complications including pneumonia.
2. Explain that the optimal body position for incentive spirometry is semi-Fowler's position which allows for free movement of the diaphragm.
3. Instruct the patient to exhale normally and evenly inhale maximally through the spirometer mouthpiece.
4. Encourage the patient to hold the maximal inspiration for a minimum of three seconds to allow for redistribution of gas and opening of atelectatic areas.
5. Instruct the patient to exhale slowly and breathe normally between maneuvers.
6. Instruct the patient to repeat this maneuver as frequently as prescribed.

PNM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about pneumonia.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding pneumonia.
2. Discuss the content of the patient information literature with the patient/family.

PNM-M MEDICATIONS

OUTCOME: The patient and/or family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Review the proper use, benefits and common side effects of prescribed medications.
2. Explain the importance of completing the full course of antibiotic therapy, as prescribed, to prevent antibiotic resistance and to facilitate complete recovery.
3. Explain the importance of adhering to the medication schedule.
4. Discuss the use of medications for symptom relief, i.e., expectorants, analgesics.
5. Discourage the use of cough suppressants for a productive cough.

PNM-N NUTRITION

OUTCOME: The patient will understand how to modify the diet to conserve energy and promote healing.

STANDARDS:

1. Stress the importance of water intake to aid in liquefying sputum.
2. Discuss the importance of the food pyramid and maintaining a balanced diet to maintain health.
3. Discuss the essential role of protein in healing.
4. Discuss changing to frequent small meals to conserve energy during the acute phase of pneumonia as appropriate.

PNM-P PREVENTION

OUTCOME: The patient/family will understand actions that may be taken to prevent pneumonia.

STANDARDS:

1. Instruct patient to avoid contact with people with upper respiratory infections.
2. Encourage patient to maintain natural resistance to infection through adequate nutrition, rest, and exercise.
3. Encourage patient (particularly if elderly or chronically ill) to obtain immunizations against influenza and pneumococcus.

PNM-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand actions that may be taken to control chest discomfort.

STANDARDS:

1. Encourage the patient to take analgesics as prescribed for chest discomfort.
2. Demonstrate how to splint the chest while coughing.

PNM-TE TESTS

OUTCOME: The patient will understand the test(s) to be performed.

STANDARDS:

1. Explain that pneumonia may be diagnosed by evidence on the chest x-ray.
2. Explain that the specific infective organism can be diagnosed from a sputum culture and gram stain. The most effective antibiotics to treat the pneumonia can be identified from a sensitivity test of the cultured organism.
3. Explain that blood cultures and blood counts may also assist in diagnosis and treatment.
4. Discuss the risks/benefits of tests ordered.

PNM-TX TREATMENT

OUTCOME: The patient/family will understand the appropriate treatment for pneumonia and the importance of fully participating with the prescribed regimen.

STANDARDS:

1. Explain that antibiotics are necessary to obliterate the infective organisms. **Refer to PNM-M.**
2. Explain that sometimes oxygen is required during the acute phase of infection to maintain adequate oxygenation.

POI—Poisoning

POI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of the treatment plan and the importance of making and keeping follow-up appointments.

STANDARDS:

1. Explain the recommended schedule for follow-up.
2. Explain the procedure for obtaining follow-up appointments
3. Explain the importance of keeping follow-up appointments.
4. Explain that failure to keep follow-up appointments may have devastating consequences.

POI-I INFORMATION

OUTCOME: The patient/family will understand the steps to take when an incident of poisoning has been identified.

STANDARDS:

1. Discuss the importance of calling the Poison Control Center immediately.
2. Emphasize that immediate treatment increases the probability of a positive outcome.
3. Explain the importance of having the substance causing the poisoning available. Explain how this will assist medical personnel in making a correct diagnosis and treatment plan.
4. Discuss the use of syrup of ipecac. Explain that ipecac should only be used on the advice of the poison control center or medical personnel.

POI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about poison prevention.

STANDARDS:

1. Provide the patient/family with written information about poison prevention.
2. Discuss the content of the patient information literature with the patient/family.

POI-P PREVENTION

OUTCOME: The parent/family will understand necessary steps to poison prevention.

STANDARDS:

1. Discuss ways to poison proof the home by keeping poisons and medications stored safely and out of reach of children, keep medicines and poisons in their original containers, and lock up cabinets containing poisons that are within reach of children.
2. Explain to parents the necessity of discussing poison control with their children. Emphasize to parents to impress upon their children that medication is not candy.
3. Emphasize that child-locks, child-resistant medication containers and other child safety devises are not truly child proof.
4. Explain that poisonous chemicals should not be stored in food or drink containers. Poisonous chemical should be kept in original, properly labeled containers.

POI-TE TESTS

OUTCOME: The patient /family will understand the conditions under which testing is necessary and the specific test(s) to be preformed, technique for collecting samples and the expected benefit of testing and any associated risks. The patient/family will also understand alternatives to testing and the potential or risks associated with the alternatives, i.e., risk of non-testing.

STANDARDS:

1. Explain that tests may be necessary for diagnosis and treatment of poisoning and for follow-up of treatment. Discuss the procedure for collecting the sample, the benefit expected and any associated risks.
2. Explain the alternatives to the proposed test(s) and the risk(s) and benefits(s) of the alternatives including the risk of non-testing.

POI-TX TREATMENT

OUTCOME: The patient/family will understand the components of the treatment plan as well as common and important side-effects, risks and benefits and the probability of success of the treatment. The patient/family will further understand the risk of non-treatment.

STANDARDS:

1. Emphasize that immediate treatment increases the probability of a positive outcome.
2. Explain the importance of having the substance causing the poisoning available. Explain how this will assist medical personnel in making a correct diagnosis and treatment plan.
3. Discuss the use of syrup of ipecac. Explain that ipecac should only be used on the advice of the poison control center or medical personnel.
4. Discuss the treatment plan for this specific poisoning. Discuss suicide precautions if this was a non-accidental poisoning. **Refer to SB.**

PDEP—Postpartum Depression

PDEP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand postpartum depression and its symptoms.

STANDARDS:

1. Explain that postpartum depression is a type of mood disorder, a biological illness caused by changes in brain chemistry, and is not the mother's fault or the result of a weak or unstable personality. It is a medical illness which professional treatment can help.
2. Explain that postpartum depression occurs in up to 80% of women who give birth, and that it is treatable.
3. Review some of the biological, psychological/social factors related to the development of postpartum depression:
    a. Biological: Sudden drop in hormones after birth and/or changes in prolactin levels.
    b. Psychological/social: Stressful life events such as financial problems, housing problems, lack of family interaction and support, new mothers facing new roles, lack of sleep, increased responsibility, single mothering, and/or marital problems.
    c. Family or personal history of depression or mood disorders with or without pregnancy.
4. Discuss that postpartum depression is often not recognized by the mother or family. Emphasize the importance of discussing mood/behavior changes with a health care provider.
5. Describe the varying degrees of postpartum depression that may occur- Postpartum Blues, Postpartum Depression, and Postpartum Psychosis:
    a. **PP Blues**: Occurs first three days after birth lasting to a few weeks - tearfulness, irritability, mood swings, nervousness, feelings of vulnerability, trouble sleeping, loss of appetite, lack of confidence, and feeling overwhelmed.
    b. **PP Depression**: Occurs within first 3-6 months up to a year after birth - sadness, loss of interest in normal activities, inappropriate guilt, anxiety, fatigue, impaired concentration/ memory, over concern for baby or non at all, inability to cope, despondency/despair, thoughts of suicide, hopelessness, panic attacks (numbness, tingling in limbs, chest pain, hyperventilation, heart palpitations), feeling "like I'm going crazy", bizarre or strange thoughts.

c. **PP Psychosis:** Rarest and most severe form occurring in only 0.1% of women who have given birth – Extreme confusion, incoherence, rapid speech or mania, refusal to eat, suspiciousness, irrational statements, agitation, hallucinations, or inability to stop an activity.

6. Explain that sometimes only a professional, through test interpretation, obtaining an appropriate history, and physical examination may be able to differentiate the degree of depression. Discuss the current knowledge of postpartum depression.
7. Emphasize that postpartum depression is reversible with early intervention and appropriate treatment. Refer as appropriate.

PDEP-FU FOLLOW-UP

OUTCOME: The patient/family will participate in the treatment plan and understand the importance of full participation with medications and observations.

STANDARDS:

1. Emphasize the importance of keeping appointments for postpartum, well child and postpartum depression care.
2. Review treatment plan with the patient/family. Discuss the procedure for obtaining follow-up care, the importance of taking medications as prescribed, and how to recognize any functional impairments (as evidenced by the avoidance of family or friends, an inability to attend to hygiene, or an inability to care adequately for the infant). Explain that patients with coexisting with substance abuse may need more rapid referral.
3. Explain that if the patient has considered a plan to act on suicidal thoughts or has thoughts about harming her infant, this is a medical emergency and hospitalization may be necessary. Discuss the procedure for obtaining urgent and rapid referrals.

PDEP-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about Postpartum Depression.

STANDARDS:

1. Provide patient/family with written information on Postpartum Depression.
2. Discuss the content of patient information literature with the patient/family.

PDEP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adaptations necessary to decrease the risk for postpartum depression and maintain optimal health.

STANDARDS:

1. Advise that the patient may be able to decrease the risk for postpartum depression by preparing during the pregnancy for the changes in lifestyle that motherhood will bring.
2. Emphasize lifestyle adaptations that will help speed recovery from postpartum depression:
    a. Over-sleeping may be a symptom of depression but has also been shown to increase depressed feelings. Discourage remaining in bed or sleeping more than 8-hours a day.
    b. Advise that natural light and exercise have an antidepressant effect. Encourage the patient to exercise, for example take a walk out of doors for at least ½-hour between 11 AM and 2 PM to take care of the need for bright light and exercise.
    c. Emphasize the importance of TOTALLY abstaining from alcohol and recreational drugs. Alcohol and street drugs both induce depression and prevent antidepressants from working effectively. Advise your provider of all medications, drugs herbals and supplements you are taking to minimize this effect.
    a. Encourage the patient/family to accept the recommended help and assistance of others. There is no shame in asking for or accepting help.

PDEP-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of medication therapy and plan to follow the prescribed medication regimen.

STANDARDS:

1. Review the patient's medications. Reinforce the importance of knowing the drug, dose and the time interval of medications.
2. Review common side effects, signs of toxicity. Discuss what actions to take if a significant side effect or signs of toxicity occurs.
3. Emphasize the importance fully participating in the medication regimen. Explain that many medications for postpartum depression do not exert an immediate effect and must be used regularly to be effective.
4. Briefly explain the mechanism of action of the patient's medication as appropriate.
5. Discuss any significant drug/drug or food/drug interactions, including interaction with alcohol.
6. Explain that the patient's wish to breast-feed can be respected. The transfer of medication to the baby can be minimized by the mother breastfeeding before she takes her pills. Although many depression medications are excreted in breastmilk, no cases of deleterious effects have been noted in infants to date. Refer the patient to a physician or pharmacist who is knowledgeable in the use of medications during breastfeeding for more specific information.

PDEP-N NUTRITION

OUTCOME: The patient/family will understand how diet relates to postpartum depression.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between diet and depression.
3. Explain that even marginal deficiencies in the diet will negatively affect the nervous system, mood and breastfeeding. A daily multivitamin and mineral supplement may be recommended to help ensure an adequate intake.
4. Assist in developing an appropriate diet plan. Refer to dietitian or other local resources as available. Stress the importance of eating on a regular schedule and eating a variety of foods.

PDEP-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in postpartum depression.

STANDARDS:

1. Explain that uncontrolled stress is attributed to an increase in severity of the symptoms of postpartum depression.
2. Explain that uncontrolled stress can interfere with the treatment of postpartum depression.
3. Explain that effective stress management may help reduce the severity of the symptoms of depression, as well as help improve the health and well-being of the patient.
4. Emphasize the importance of seeking professional help as needed to reduce stress.
5. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all of which can increase the severity of the depression or the risk of suicidal/homicidal behaviors.
6. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. recruiting other family members or friends to help with child care
    d. talking with people you trust about your worries or problems
    e. setting realistic goals
    f. getting enough sleep (e.g., sleeping when the baby sleeps if possible)
    g. maintaining a reasonable diet
    h. exercising regularly
    i. taking vacations
    j. practicing meditation
    k. self-hypnosis
    l. using positive imagery
    m. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    n. spiritual or cultural activities
7. Provide referrals as appropriate.

PDEP-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available based on the specific disease process, test results, severity of symptoms, the preferences of the patient, and the response to treatment during previous episodes.

STANDARDS:

1. Assist the patient/family in understanding that postpartum depression may require long-term intervention which may include psychotherapy, medication, support groups or electro-convulsive therapy.
2. Review the nature of postpartum depression as a treatable condition.
3. Explain that both the patient AND family may need to participate in the treatment to help understand the symptoms and cope with the increased stress on the family.
4. Assist the family in the realization that left untreated, postpartum depression can have significant negative effects on the baby that can persist into adulthood. It is therefore very important to identify and treat postpartum depression as early as possible.
5. Urge the family/patient to find someone to stay with and assist the patient at all times. Family and friends may offer support, reassurance, hope, and validation of the new mother's abilities.
6. Explain that treatment may begin at any point, even prior to pregnancy depending on the circumstance.

PDM—Prediabetes

PDM-C COMPLICATIONS

OUTCOME: The patient/family/caregiver will understand common or serious complications of abnormal fasting blood glucose level.

STANDARDS:

1. Explain that fasting blood glucose levels above 100 mg/dL but less than 126 mg/dL and 2 hour post prandial between 140-200 mg/dL are diagnostic of prediabetes and that prediabetes may progress to Type 2 Diabetes.
2. Emphasize that optimal control of blood sugar can reverse or prevent progression of PDM.
3. Emphasize that optimal control of blood sugar can reduce the risk of complications.
4. State that PDM is a disease that needs to be monitored for progression and complications. Routine examinations are essential.
5. Discuss higher risk factors of PDM, i.e., heart attack, stroke. **Refer to CVA, CAD, DM and PVD.**
6. Discuss complications that can occur if PDM develops into Diabetes, i.e., heart disease, stroke, eye problems, kidney damage.

PDM-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of PDM.

STANDARDS:

1. Briefly describe the pathophysiology of PDM.
2. Discuss the role of insulin resistance in PDM and Type 2 DM.
3. Describe risk factors for development and progression of PDM, i.e., including: family history, obesity, sedentary lifestyle, previous history of gestational diabetes, history of high blood pressure, high triglycerides.
4. Emphasize that PDM is a reversible, controllable condition, which requires permanent lifestyle alterations and continuous attention and medical care. **Refer to PDM-LA**.

PDM-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in reducing insulin resistance and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that increased physical activity will reduce the body's resistance to insulin.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

PDM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in preventing the progression of PDM . The patient/family will develop a plan to make and keep follow-up appointments.

STANDARDS:

1. Emphasize the importance of early intervention to prevent the progression of PDM to Type 2 Diabetes.
2. Discuss the procedure for making appointments.
3. Discuss any necessary preparation for lab test(s). **Refer to PDM-TE**.

PDM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about PDM.

STANDARDS:

1. Provide the patient/family with written patient information on PDM.
2. Discuss the content of the patient information with the patient/family.

PDM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family/caregiver will understand the lifestyle adaptations necessary to prevent or delay the progression of PDM and develop a realistic plan to accomplish this.

STANDARDS:

1. Emphasize that nutrition and exercise are the critical components in improving impaired glucose tolerance.
2. Emphasize that the complications (i.e., heart attack, stroke) result from the higher than normal blood sugar levels and that the goal of management is to keep blood sugar as near to normal as possible.

PDM-N NUTRITION

OUTCOME: The patient/family will understand the importance of nutritional management in the control of PDM and develop a plan to meet nutritional goals.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation and intake.
2. Review the food pyramid and its role in meal planning. Refer to registered dietician or to other local resources as appropriate.
3. Emphasize the importance of reading food labels. Instruct the patient/family as necessary.
4. Discuss the merits of various food preparation methods, i.e., broiling or baking is preferred over frying, avoid gravies and sauces, rinsing or blotting excess grease.
5. Emphasize the importance of portion control (appropriate serving sizes).
6. Emphasize that extra caution or planning is required when eating out, using USDA commodities, or going to special events since these foods are usually high in fat and sugar and serving sizes are often inappropriately large.
7. Emphasize that carbohydrates (such as whole grains) and low-fat proteins are preferred and that sugars and fats should be limited.
8. Emphasize the importance of family involvement and early intervention.

PDM-P PREVENTION

OUTCOME: The patient/family will understand major risk factors for development of PDM and will develop a plan for risk reduction.

STANDARDS:

1. Discuss the risk factors for PDM and Type 2 DM, i.e., obesity, sedentary lifestyle.
2. Explain that following an appropriate meal plan and increasing activity levels will reduce the risk of progression of PDM to Type 2 Diabetes.
3. Emphasize the importance of regular screening. Discuss current recommendations for screening.

PDM-TE TESTS

OUTCOME: The patient/family will understand the test to be performed and the reasons for the testing.

STANDARDS:

1. Explain the test(s) ordered, i.e., FBS, $HgbA_{1C}$, Fasting Lipid Profile.
2. Explain any necessary preparation prior to the test(s).
3. Explain the indications, risks and benefits of the test(s).
4. Explain the meaning of test results in relation to what "normal" results are.
5. Explain the test as it relates to planning the course of treatment.

PL—Pulmonary Disease

PL-BIP BILEVEL (OR CONTINUOUS) POSITIVE AIRWAY PRESSURE VENTILATION

OUTCOME: The patient/family will have a basic understanding of BiPAP or CPAP ventilation, as well as the risks, benefits, alternatives to BiPAP or CPAP and associated factors affecting the patient.

STANDARDS:

1. Explain that the patient does not require intubation with an endotracheal tube or tracheostomy tube in order to receive BiPAP or CPAP. BiPAP or CPAP is delivered utilizing a tight-fitting mask over the nose and/or mouth.
2. Explain the basic mechanics of BiPAP or CPAP, including the risks and benefits of receiving BiPAP or CPAP and the adverse events which might result from refusal.
3. Discuss alternatives to BiPAP or CPAP, including expectant management, endotracheal intubation or tracheostomy as appropriate.
4. Explain that patient cooperation is vital to successful BiPAP or CPAP management.

PL-C COMPLICATIONS

OUTCOME: The patient will understand how to prevent complications of pulmonary disease.

STANDARDS:

1. Discuss that the most common complications of pulmonary disease are exacerbation or infection. These complications often result from failure to fully participate with treatment regimens (i.e., medications, peak flows) or from exposure to environmental triggers or infections.
2. Emphasize early medical intervention for minor URI's, fever, cough, and shortness of breath.
3. Stress the importance of fully participating in the treatment plan.

PL-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PL-DP DISEASE PROCESS

OUTCOME: The patient will understand the etiology and pathophysiology of their pulmonary disease.

STANDARDS:

1. Review the anatomy and physiology of the respiratory system.
2. Discuss how factors such as: environmental triggers, age, smoking, COPD, and asthma affect the ability of the respiratory system to exchange O_2/CO_2 and resist infection.
3. Discuss the pathophysiology of the patient's specific disease process.

PL-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

PL-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in this patient's disease process and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
2. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
3. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
4. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
5. Discuss medical clearance issues for physical activity.

PL-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of regular follow-up and will strive to keep scheduled appointments.

STANDARDS:

1. Discuss the importance of regular follow-up care in the prevention of complications and adjustment of medications.
2. Encourage full participation in the treatment plan. Assess the patient's understanding of the treatment plan and acceptance of the diagnosis.
3. Provide positive reinforcement for areas of achievement.
4. Refer to PHN or community resources as appropriate.
5. Emphasize the importance of consistent peak flow measurement if appropriate.

PL-HM HOME MANAGEMENT

OUTCOME: The patient and/or family will understand the home management of their disease process and make a plan for implementation.

STANDARDS:

1. Discuss home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer emergency room visits and fewer hospitalizations.

PL-INT INTUBATION

OUTCOME: The patient/family will have a basic understanding of endotracheal intubation, as well as the risks, benefits, alternatives to endotracheal intubation and associated factors affecting the patient.

STANDARDS:

1. Explain the basic procedure for endotracheal intubation, including the risks and benefits of endotracheal intubation and the adverse events which might result from refusal.
2. Discuss alternatives to endotracheal intubation, including expectant management, as appropriate.
3. Explain that the patient will be unable to speak or eat while intubated.

PL-IS INCENTIVE SPIROMETRY

OUTCOME: The patient will understand the reason for use of the incentive spirometer and demonstrate appropriate use.

STANDARDS:

1. Explain that regular and appropriate use of the incentive spirometer according to instructions reduces the risk of respiratory complications including pneumonia.
2. Explain that the optimal body position for incentive spirometry is semi-Fowler's position which allows for free movement of the diaphragm.
3. Instruct the patient to exhale normally and evenly inhale maximally through the spirometer mouthpiece.
4. Encourage the patient to hold the maximal inspiration for a minimum of three seconds to allow for redistribution of gas and opening of atelectatic areas.
5. Instruct the patient to exhale slowly and breathe normally between maneuvers.
6. Instruct the patient to repeat this maneuver as frequently as prescribed.

PL-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about pulmonary disease.

STANDARDS:

1. Provide the patient/family with written patient information literature on pulmonary disease.
2. Discuss the content of the patient information literature with the patient/family.

PL-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will strive to make the lifestyle adaptations necessary to prevent complications of pulmonary disease and prolong life.

STANDARDS:

1. Discuss lifestyle changes which the patient has the ability to make: cessation of smoking, dietary modifications, weight control, participation in treatment and exercise.
2. Re-emphasize how complications of pulmonary disease can be reduced or eliminated by such changes.
3. Review the community resources available to help the patient in making such lifestyle changes.
4. Identify and avoid environmental triggers (i.e., cigarette smoke, stress, environmental smoke, pollen, mold, dust, roaches, insecticides, paint fumes, perfumes, animal dander, cold air, sulfites, aspirin) as appropriate for the patient.

PL-M MEDICATIONS

OUTCOME: The patient and/or family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Review the patient's medications. Reinforce the importance of knowing the drug, dose, and dosing interval of medications.
2. Review common side effects, signs of toxicity, and drug interactions of medication(s).
3. Discuss the difference between bronchodilator and anti-inflammatory medications.
4. Explain the difference between maintenance and rescue drugs.
5. Emphasize full participation with the treatment plan and explain how effective use of medications can facilitate a more active life style for the pulmonary disease patient.
6. Emphasize the importance of consulting with a health care provider prior to using any OTC medication.

PL-MDI METERED-DOSE INHALERS

OUTCOME: The patient will be able to demonstrate correct technique for use of MDIs and understand their role in the management of pulmonary disease.

STANDARDS:

1. Instruct and demonstrate steps for standard or alternate use procedure for metered-dose inhalers and ways to clean and store the unit properly.
2. Review the importance of using consistent inhalation technique.

PL-N NUTRITION

OUTCOME: The patient will understand how to modify diet to conserve energy and promote nutritional balance.

STANDARDS:

1. Assess the patient's current nutritional patterns. Review how these patterns might be improved.
2. **Refer to WL-N.**
3. Stress the importance of water intake to aid in liquefying sputum.
4. Explain how meal planning may need to be individualized for specific pulmonary disorders. Consider eliminating milk because it increases mucous production. Foods which are gas producing may hinder diaphragmatic movement. Several small meals instead of three large meals may be indicated to reduce respiratory effort. Refer to dietitian as appropriate.

PL-NEB NEBULIZER

OUTCOME: The patient will be able to demonstrate effective use of the nebulizer device, discuss proper care and cleaning of the system, and describe its place in the care plan.

STANDARDS:

1. Describe proper use of the nebulizer including preparation of the inhalation mixture, inhalation technique, and care of equipment.
2. Discuss the nebulizer treatment as it relates to the medication regimen.

PL-O2 OXYGEN THERAPY

OUTCOME: The patient and/or family will understand the need for and be able to demonstrate the proper use of oxygen administration equipment.

STANDARDS:

1. Discuss the dangers of ignition sources around oxygen, i.e., cigarettes, sparks, flames.
2. Emphasize the importance of regular maintenance checks of oxygen equipment.
3. Emphasize that O2 flow rate should not be changed except upon the order of a physician, since altering the flow rate may worsen the condition.
4. Discuss use, care, and cleaning of all equipment.
5. Explain the reason for O_2 therapy and the anticipated benefit.

PL-PF PEAK-FLOW METER

OUTCOME: The patient will be able to demonstrate correct use of the peak-flow meter and explain how its regular use can help achieve a more active lifestyle.

STANDARDS:

1. Discuss use and care of the peak flow meter as a tool for measurement of peak expiratory flow rate (PEFR) and degree of airway obstruction. Discuss peak flow zones in management of airway disease.
2. Explain how monitoring measurement of PEFR can provide an objective way to determine current respiratory function.
3. Emphasize how a regular monitoring schedule can help determine when emergency care is needed, prevent exacerbations through early intervention, and facilitate management of the pulmonary disease.

PL-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient; and may be multifaceted. **Refer to PM.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Explain non-pharmacologic measures that may be helpful with pain control.

PL-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure(s), as well as the risks, benefits, alternatives to the proposed procedure(s) and associated factors affecting the patient.

STANDARDS:

1. Explain the specific procedure(s) to be performed, including the risks and benefits of performing the procedure and the adverse events which might result from refusal of the procedure.
2. Discuss alternatives to the proposed procedure(s), including expectant management, as appropriate.
3. Discuss the expected patient/family involvement in the care required following the proposed procedure(s).

PL-SHS SECOND-HAND SMOKE

OUTCOME: Provide the patient and/or family with an understanding of the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls.
2. Discuss harmful substances in smoke
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness in the pulmonary patient when exposed to cigarette smoke either directly or via second-hand smoke.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the pulmonary patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage smoking cessation or at least never smoking in the home or car.

PL-SPA SPACERS

OUTCOME: The patient will be able to demonstrate the correct use of spacers and understand their importance in delivery of medications.

STANDARDS:

1. Instruct and demonstrate proper technique for spacer use.
2. Discuss proper care and cleaning of spacers.
3. Explain how spacers improve the delivery of inhaled medications.

PL-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

PL-TO TOBACCO (SMOKING)

OUTCOME: The patient and/or family will understand the dangers of smoking or exposure of the pulmonary patient to cigarette smoke and develop a plan to eliminate said exposure.

STANDARDS:

1. Explain the increased risk of illness in the pulmonary patient when exposed to cigarette smoke either directly or via second-hand smoke.
2. Explain that cigarette smoke gets trapped in carpets and upholstery and still increases the risk of illness even if the pulmonary patient is not in the room at the time that the smoking occurs.
3. Encourage smoking cessation or at least NEVER smoking in the home or car.
4. **Refer to TO.**

PL-VENT MECHANICAL VENTILATION

OUTCOME: The patient/family will understand mechanical ventilation, as well as the risks, benefits, alternatives to mechanical ventilation and associated factors affecting the patient.

STANDARDS:

1. Explain that the patient must be intubated with an endotracheal tube or tracheostomy tube in order to receive mechanical ventilation.
2. Explain the basic mechanics of mechanical ventilation, including the risks and benefits of receiving mechanical ventilation and the adverse events which might result from refusal.
3. Discuss alternatives to mechanical ventilation, including expectant management, as appropriate.
4. Explain that the patient will be unable to speak or eat while intubated and receiving mechanical ventilation.
5. Explain that the patient will be sedated during intubation and the initiation of mechanical ventilation.
6. Discuss the possibility that the patient may require restraints to prevent accidental extubation.

R

XRAY—Radiology/Nuclear Medicine

XRAY-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and important complications that may result from this procedure.

STANDARDS

1. Explain that some patients may have adverse reactions to contrast media or other medications used during radiographic/nuclear medicine procedures.
2. Discuss common and important complications as they apply to the procedure to be performed.
3. Discuss the procedure that will be undertaken if adverse events occur.

XRAY-FU FOLLOW-UP

OUTCOME: The patient/family will understand the conditions that would require follow-up and how to obtain follow-up.

STANDARDS:

1. Discuss the findings that will signify a serious complication or condition.
2. Discuss the procedure for obtaining follow-up appointments.

XRAY-L LITERATURE

OUTCOME: The patient/family will receive written information about the disease process or condition.

STANDARDS:

1. Provide patient/family with written patient information on the disease state or condition.
2. Discuss the content of patient information literature with the patient/family.

XRAY-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of medication therapy as it relates to the procedure to be performed.

STANDARDS:

1. Discuss the proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
2. Emphasize the importance of full participation with medication regimen.
3. Discuss the mechanism of action as needed.
4. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
5. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

XRAY-PRO PROCEDURE

OUTCOME: The patient/family will understand the radiographic/nuclear medicine procedure to be performed.

STANDARDS:

1. Discuss the method of the radiographic/nuclear medicine procedure that has been ordered.
2. Discuss the indications, risks, and benefits for the proposed procedure.
3. Explain the process and what to expect after the procedure.
4. Explain the necessary preparation, i.e., bowel prep, diet instructions, bathing.
5. Discuss pain management as appropriate.
6. Emphasize post-procedure management and follow-up.

XRAY-S SAFETY

OUTCOME: Explain the procedure used to protect the patient and staff.

STANDARDS:

1. Discuss the use of personal protective equipment (i.e., lead shields, gloves) and their role in preventing transmission of disease or unnecessary radiation exposure.
2. Demonstrate the proper use of equipment to be used.
3. Discuss as appropriate that needles and other infusion equipment are single patient use and will be discarded.
4. Discuss the procedure for accidental needle-stick of the patient or the staff as appropriate.

XRAY-TE TESTS

OUTCOME: The patient/family will understand the test to be performed.

STANDARDS:

1. Explain the test that has been ordered.
2. Explain the necessity, benefits, and risks of the test to be performed. Refer to the primary provider as necessary.
3. Explain any necessary preparation for the test, i.e., fasting.
4. Explain the procedure for obtaining test results.

RSV—Respiratory Syncytial Virus

RSV-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and serious complications of RSV.

STANDARDS:

1. Discuss that many children with RSV also develop and ear infection (about 20% of the time).
2. Explain that only 1-2% of children with RSV will need hospitalization for oxygen or IV fluids.
3. Discuss that recurrent wheezing happens mostly in children who have close relatives with asthma. Some percentage of children who have RSV will go on to develop asthma.

RSV-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the disease process of RSV.

STANDARDS:

1. Explain that RSV is caused by a virus. Explain that viral illnesses are not made better by antibiotics.
2. Discuss that the virus causes a swelling of the smallest airways in the lungs (bronchioles). This narrowing results in wheezing and difficulty breathing. The wheezing and difficulty breathing typically gets worse for 2-3 days then begins to improve. The acute phase of the disease is usually 7-14 days long.
3. Discuss that recurrent wheezing happens mostly in children who have close relatives with asthma. Some percentage of children who have RSV will go on to develop asthma.
4. Explain that RSV is spread by droplets containing the virus. These droplets are usually created by the infected person coughing or sneezing them out. Infection usually occurs by touching the droplets then rubbing one's eyes or nose. Hand washing is the best way to prevent infection.
5. Discuss, as appropriate, that the worst disease happens in children less than 2 years of age. People older than this who become infected with RSV will usually experience severe cold-like symptoms.

RSV-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and strive to keep scheduled appointments.

STANDARDS:

1. Discuss the importance of keeping scheduled appointments to monitor the seriousness of the disease and prevention or treatment of complications.
2. Encourage full participation with the treatment plan. Assess the patient's understanding of the treatment plan and acceptance of the diagnosis.
3. Refer to PHN or community resources as appropriate.

RSV-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management plan and the importance of following the plan. Discuss the following standards as applicable to this patient.

STANDARDS:

1. Explain that dry air tends to make cough worse. Discuss the use of a humidifier to loosen secretions and soothe the airway.
2. Discuss the use of suction devices (such as bulb syringes) to remove sticky mucus from the nose and make breathing easier. Discuss the use of nasal saline drops to loosen the mucus.
3. Explain that warm liquids may be helpful to loosen secretions in the back of the throat and relieve coughing spasms. This may not be appropriate for very young infants.

RSV-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about RSV.

STANDARDS:

1. Provide the patient/family with written patient information literature on asthma.
2. Discuss the content of the patient information literature with the patient/family.

RSV-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and be able to demonstrate and explain the use of the prescribed medication regimen.

STANDARDS:

1. Review the patient's medication(s). Reinforce the importance of knowing the drug, dose, and dosing interval of medications.
2. Review common side effects, signs of toxicity, and drug interaction of medications(s).
3. Emphasize fully participating in the medication plan and explain how effective use of medications may reduce the risk of complications or hospital admission, as appropriate.

RSV-NEB NEBULIZER

OUTCOME: The patient/family will be able to demonstrate effective use of the nebulizer device, discuss proper care and cleaning of the system, and describe its place in the care plan.

STANDARDS:

1. Describe proper use of the nebulizer, including preparation of the inhalation mixture, inhalation technique (i.e., masks, blow-by), and care of the equipment.
2. Discuss the nebulizer treatment as it relates to the medication regimen.

RSV-P PREVENTION

OUTCOME: The patient/family will understand ways to help prevent RSV infection or spread of infection.

STANDARDS:

1. Explain that RSV is spread by contact with contaminated objects. Discuss the importance of hand washing and of disinfecting toys (especially in the day care setting).
2. Discuss the availability of passive immunization for RSV for selected groups of children, as appropriate. (Currently the recommendation for prophylaxis is children <24 months of age with bronchopulmonary dysplasia or with a history of premature birth (<32 weeks gestation). Refer to current literature for any updates on these recommendations.)

RSV-SHS SECOND-HAND SMOKE

OUTCOME: Provide the patient and/or family with an understanding of the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls.
2. Discuss harmful substances in smoke
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness in the RSV patient when exposed to cigarette smoke either directly or via second-hand smoke.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage smoking cessation or at least never smoking in the home or car.

RSV-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed.

STANDARDS:

1. Explain the test(s) ordered, i.e., nasopharyngeal wash or swab, pulsoximetry.
2. Explain the necessity, benefits and risks of the test(s) to be performed.
3. Explain how the testing relates to the course of treatment.

RSV-TO TOBACCO (SMOKING)

OUTCOME: The patient/family will understand the dangers of exposure of the patient with RSV to cigarette smoke and develop a plan to eliminate said exposure.

STANDARDS:

1. Explain the increased risk of hospitalization and serious or life threatening illness when a patient with RSV is exposed to cigarette smoke.
2. Explain that cigarette smoke gets trapped in carpets and upholstery and still increases the risk of illness even if the patient with RSV is not in the room at the time that the smoking occurs.
3. Encourage smoking cessation or at least NEVER smoking in the home or car.

RD—Rheumatic Disease

RD-C COMPLICATIONS

OUTCOME: The patient will understand how to lessen complications of rheumatic disease.

STANDARDS:

1. Review the common complications associated with the patient's disease.
2. Review the treatment plan with the patient. Explain that complications are worsened by not participating with the treatment plan.

RD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of rheumatic disease.

STANDARDS:

1. Review the disease process of the patient's rheumatic disease.
2. Review the physical limitation that may be imposed by the patient's disease.
3. Explain that treatments are highly individualized and may vary over the course of the disease.
4. Refer to the Arthritis Foundation or community resources as appropriate.

RD-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.

RD-EX EXERCISE

OUTCOME: The patient will maintain an optimal level of mobility with minimal discomfort.

STANDARDS:

1. Emphasize that exercise is an important component of the treatment plan. Stress the importance of balancing rest and exercise.
2. Explain that exercise, when done correctly, can help reduce rheumatic disease symptoms, including the following:
    a. Preventing joint stiffness
    b. Keeping muscles strong around the joints
    c. Improving joint flexibility
    d. Reducing pain
    e. Maintaining strong and healthy bone and cartilage tissue
    f. Improving joint alignment
    g. Improving overall fitness
3. Emphasize that exercise can also help with weight reduction and contributes to an improved sense of well-being, enhance sleep, and reduce stress and depression.
4. Review the different types of exercises including active and passive range of motion, muscle strengthening and endurance exercises.
5. If applicable, review and demonstrate the prescribed exercise plan.
6. Emphasize the importance of "warm-ups and cool-downs". Explain how the application of heat or cold prior to beginning exercise may reduce joint discomfort. Explain that people who have poor circulation should talk to their healthcare provider before using hot or ice packs.
7. Caution the patient not to overexert. Stress the importance of taking a break when experiencing pain or fatigue.

RD-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of fully participating in the treatment plan and regular follow-up.

STANDARDS:

1. Discuss the patient's responsibility in managing rheumatic disease.
2. Review treatment plan with the patient/family, emphasizing the need for keeping appointments and adhering to medications regimens.

RD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about rheumatic disease.

STANDARDS:

1. Provide the patient/family with written patient information literature on rheumatic disease.
2. Discuss the content of the patient information literature with the patient/family.

RD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle changes necessary to optimize performance of everyday activities.

STANDARDS:

1. Discuss that treatment for arthritis is usually a combination of rest and relaxation, exercise, proper diet, medication, joint protection and ways to conserve energy. Discuss way to pain management. **Refer to RD-PM**.
2. Review activity limitation and the importance of avoiding fatigue.
3. Discuss ADL aids. Make a referral to social services for assistance in procuring such devices.
4. Explain how exercise and social involvement may decrease the depression and anger often associated with rheumatoid disease.
5. Discuss how self-image, pain, fatigue, inflammation, limited joint mobility, and medications can alter sexual desire and sexual activity.
6. Assess level of acceptance and offer support and referral to social services and community resources as appropriate.
7. Discuss the importance of relaxation to minimize stress, thus minimizing symptoms. A relaxed body means the muscles are relaxed, relieving some of the pain associated with rheumatic disease.
8. Discuss the techniques that may reduce stress and depression such as meditation, imagery, prayer, hypnosis, and biofeedback.
9. **Refer to WL**.

RD-M MEDICATIONS

OUTCOME: The patient/family will understand the proper use of anti-rheumatic medications.

STANDARDS:

1. Review the mechanism of action of the prescribed medication.
2. Discuss proper use, benefits and common side effects of prescribed medications.
3. Explain that some medications may have long-term effects which require regular monitoring and follow-up.
4. Explain the importance of consulting with a health care provider prior to using OTC medications, or other non-prescribed or illicit drugs. **Refer to CPM and PM.**
5. Discourage the use of alcohol, since it worsens most rheumatic diseases in the long term.
6. Explain that many rheumatic diseases are chronic, making long-term management of pain and symptoms of the disease very important.

RD-N NUTRITION

OUTCOME: The patient will strive to achieve and maintain a safe weight level through a nutritionally balanced diet.

STANDARDS:

1. Assess the patient's current nutritional patterns and review improvements which can be made. **Refer to WL-N.**
2. Explain that a well-balanced diet helps to manage body weight and provides the body with the nutrients it needs to stay healthy.
3. Refer to a Registered Dietitian.

RD-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the patient's pain management program.

STANDARDS:

1. Stress the need to fully participate with the prescribed treatment plan.
2. Emphasize the importance of rest and avoidance of fatigue.
3. Discuss the use of heat and cold.
4. Discuss the techniques that may reduce stress and depression such as meditation and bio-feedback.
5. Emphasize the role of exercise in reducing pain, maximizing mobility, and reducing stress/anxiety.
6. Refer to physical therapy as appropriate.

RD-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

S

SZ—Seizure Disorder

SZ-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications of the patient's seizure disorder.

STANDARDS:

1. Explain some of the complications that may occur during a seizure, i.e., anoxia from airway occlusion by the tongue or by vomitus, traumatic injury, potential for automobile accident.
2. Explain that uncontrolled seizures may result in progressive brain injury.

SZ-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

SZ-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of seizure disorders.

STANDARDS:

1. Explain that seizures are usually paroxysmal events associated with abnormal electrical discharges of the neurons of the brain.
2. Explain that at least 50% of seizure disorders are idiopathic. No cause can be found and the patient has no other neurologic abnormalities.
3. Discuss the patient's specific type of seizure disorder if known.
4. Explain that following a seizure it is usual for a patient to have a period of increased sleepiness (postictal phase).

SZ-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of regular follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of regular follow-up care in the prevention of complications and adjustment of medications.
2. Encourage full participation in the treatment plan. Discuss the patient/family responsibility in the management of seizure disorder.
3. Discuss the mechanism for obtaining follow-up appointments.

SZ-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about seizure disorders.

STANDARDS:

1. Provide the patient/family with written patient information literature about seizure disorders.
2. Discuss the content of the patient information literature with the patient/family.

SZ-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the impact of a seizure disorder on the patient/family's lifestyle and make a plan for needed adaptations.

STANDARDS:

1. Explain the importance of full participation with therapy to reduce seizure risk.
2. A normal lifestyle should be encouraged. Explain the particular risks of driving and participation in sports or other potentially hazardous activities if the seizure disorder is poorly controlled.
3. Emphasize a common sense attitude toward the patient's illness. Emphasis should be placed on independence and preventing invalidism.
4. Teach the patient's family how to care for the patient during a seizure, i.e.:
    a. Avoid restraining the patient during a seizure
    b. Help the patient to a lying position, loosen any tight clothing, and place something flat and soft such as a pillow under his/her head
    c. Clear the area of hard objects
    d. Avoid forcing anything into the patient's mouth
    e. Avoid using tongue blades or spoons as this may lacerate the patient's mouth, lips or tongue or displace teeth, and may precipitate respiratory distress.
    f. Turn the patient's head to the side to provide an open airway
    g. Reassure the patient after the seizure subsides, orienting him/her to time and place and informing him/her about the seizure.
5. Encourage the patient to get enough sleep as excessive fatigue may precipitate a seizure.
6. Discourage use of alcohol and street drugs as these may precipitate seizures.
7. Encourage the patient to learn to control stress, i.e., relaxation techniques.
8. Discuss the need to avoid photic stimulation such as strobe lights, emergency vehicle lights, light from some ceiling fans or any intermittent repeating light source.
9. Instruct that pregnancy or hormone replacement therapy may lower a person's seizure threshold.
10. Inform the family to keep track of duration, frequency and quality of seizure. Bring this log to the health care provider on follow-up.
11. Refer to community resources as appropriate.

SZ-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and be able to demonstrate and explain the use of prescribed medication.

STANDARDS:

1. Explain the importance of full participation with the prescribed medication schedule. Review the patient's medications. Reinforce the importance of knowing the drug dose and dosing intervals.
2. Review common and important side effects, signs of toxicity, and drug/drug, and drug/food interactions. Review signs of toxicity that should prompt immediate evaluation. Of note there is an interaction between most seizure medications and birth control pills that may make the contraceptive less reliable.
3. Explain the importance of having anticonvulsant blood levels checked at regular intervals even if seizures are under control as applicable.
4. Explain how consistent use of anticonvulsant medications as prescribed can facilitate a more active lifestyle by improved seizure control.
5. Emphasize the importance of notifying the health care provider if the patient is not taking the medication as prescribed.
6. Advise women of childbearing age to inform their health care provider prior to becoming pregnant or as soon as pregnancy is expected as many anticonvulsant medications may be teratogenic.

SZ-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand the necessary measures to undertake to avoid injury of the patient or others.

STANDARDS:

1. Teach the patient's family how to care for the patient during a seizure, i.e.:
   a. Avoid restraining the patient during a seizure
   b. Help the patient to a lying position, loosen any tight clothing, and place something flat and soft such as a pillow under his/her head.
   c. Clear the area of hard objects
   d. Avoid forcing anything into the patient's mouth
   e. Avoid using tongue blades or spoons as this may lacerate the patient's mouth, lips or tongue or displace teeth, and may precipitate respiratory distress.
   f. Turn the patient's head to the side to provide an open airway
   g. Reassure the patient after the seizure subsides, orienting him/her to time and place and informing him/her about the seizure.
2. Explain the particular risks of driving and participation in sports or other potentially hazardous activities if the seizure disorder is poorly controlled.

SZ-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in seizure disorders.

STANDARDS:

1. Explain that uncontrolled stress is linked with an increased frequency of seizures.
2. Explain that effective stress management may reduce the occurrence of seizures, as well as help improve the patient's health and well-being.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use, all of which can increase the risk of morbidity and mortality of seizure disorders.
4. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
5. Provide referrals as appropriate.

SZ-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

SARS—Severe Acute Respiratory Syndrome

SARS-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential consequences of exposure to and/or infection with the SARS virus.

STANDARDS:

1. Discuss with the patient/family the common or significant complications that may occur after infection with the SARS virus.
2. Discuss common or significant complications which may be prevented by full participation with the treatment regimen.
3. Discuss common or significant complications which may result from treatment(s).

SARS-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology, symptoms and prognosis of infection with the SARS virus.

STANDARDS:

1. Explain that SARS is a respiratory illness that is caused by a new virus, (called the SARS virus); the SARS virus is similar to the coronavirus, which is a frequent cause of the common cold. Explain that the SARS virus was discovered after February 1, 2003 so infections prior to this date are unlikely to have been diagnosed as SARS.
2. Explain that symptoms usually start two to seven days after exposure to SARS. Explain that the SARS virus may spread through face-to-face contact, airborne spread, contact with contaminated stool, or possibly environmental factors.
3. Discuss the current information regarding causative factors and pathophysiology of infection with the SARS virus.
4. Discuss the signs/symptoms and usual progression of SARS. Explain that infection with SARS begins with a fever of 100.5 degrees Fahrenheit or higher with or without rigors, which may be accompanied by other nonspecific symptoms such as fatigue, headache, and myalgias. After three to seven days, respiratory symptoms such as a nonproductive cough and dyspnea may begin. This may progress to respiratory failure and require artificial means of ventilation, i.e., intubation and/or mechanical ventilation.
5. Explain that some cases may be very severe and result in death while others may result in less severe cases similar to the common cold. Discuss that some groups, such as the elderly, persons with diabetes, pulmonary disease or other chronic illnesses, are at increased risk of severe disease.

SARS-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

SARS-HM HOME MANAGEMENT

OUTCOME - The patient/family will understand the necessity of home management of their disease as appropriate and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., prevention of the spread of the SARS virus. **Refer to SARS–LA**.
3. Explain the use and care of any necessary home medical equipment.

SARS-HY HYGIENE

OUTCOME: The patient will recognize good personal hygiene as an aspect of wellness.

STANDARDS:

1. Discuss the importance of personal hygiene to prevent the spread of the SARS virus.
2. Emphasize the importance of hand washing to prevent the spread of SARS.
3. Explain that utensils, towels, and bedding should not be shared without proper washing.

SARS-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the disease process or condition.

STANDARDS:

1. Provide patient/family with written patient information on the disease state or condition.
2. Discuss the content of patient information literature with the patient/family.

SARS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle adaptations that may be necessary to prevent the spread of the of the SARS virus to others or to improve physical health.

STANDARDS:

1. Discuss the importance of good hygiene and avoidance of high risk behaviors.
2. Discuss the current recommendations regarding quarantine or other methods to reduce the spread of SARS virus.
3. Review the community resources available to assist the patient in making lifestyle changes. Refer as appropriate.

SARS-M MEDICATIONS

OUTCOME - The patient/family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Explain that there are currently no medications (treatment or vaccine) to treat infection with the SARS virus. Some medications may help to alleviate the symptoms or prevent complications associated with the infection.
2. Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
3. Emphasize the importance of full participation with medication regimen.
4. Discuss the mechanism of action as needed.
5. Emphasize the importance of consulting with a health care provider prior to initiate any new medications, including over-the-counter medications.
6. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

SARS-P PREVENTION

OUTCOME - The patient/family will understand that healthy lifestyle behaviors can reduce the risk of developing diseases, conditions, or complications.

STANDARDS:

1. Discuss activities that decrease the risk for contracting the SARS virus such as avoidance of people exposed to the SARS virus or who have SARS and following CDC travel advisories. It is not known whether wearing a surgical mask prevents the spread or contracting of the SARS virus.
2. Discuss the importance of good hygiene and avoidance of high risk behavior.
3. Explain that the SARS virus can be contracted more than once.

SARS-TE TESTS

OUTCOME - The patient/family will understand the test(s) to be performed including indications and its impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
3. Explain any necessary preparation for the test, i.e., fasting.
4. Explain the meaning of test results.
5. Explain the implications of refusal of testing.

SARS-TX TREATMENT

OUTCOME - The patient/family will understand the possible treatments that may be available for SARS.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options.
2. Discuss the treatment plan including lifestyle adaptations, pharmacologic, surgical, and psychosocial aspects of the treatment plan.
3. Discuss the importance of adhering to the treatment plan, including scheduled follow-up.
4. Refer to community resources as appropriate.

STD—Sexually Transmitted Disease

Refer to **STI—Sexually Transmitted Infections**.

STI—Sexually Transmitted Infections

STI-C COMPLICATIONS

OUTCOME: The patient/family/partner will understand the common and important complications of sexually transmitted infections.

STANDARDS:

1. Explain that the most common complication of untreated or progressed STI is pelvic inflammatory disease, infertility, and/or sterility.
2. Explain that some STIs if left untreated can progress to disability, disfigurement, and/or death.
3. Discuss that having one sexually transmitted infection greatly increases a person's risk of having a second sexually transmitted infection.
4. Explain the importance of HIV testing.
5. Discuss that some sexually transmitted infection can be life-long or fatal.
6. Discuss the potential for harm to a fetus from the sexually transmitted infection or its treatment.

STI-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

STI-FU FOLLOW-UP

OUTCOME: The patient/family/partner will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

STI-I INFORMATION

OUTCOME: The patient/family/partner will understand risk factors, transmission, symptoms and complications of causative agent(s).

STANDARDS

1. Discuss specific STI.
2. Explain the importance of partner(s) notification in the treatment and prevention of the spread of infection.
3. Explain how STIs are transmitted, i.e., semen, vaginal fluids, blood, mother to infant during pregnancy, child birth, breastfeeding, skin-to-skin contact.
4. Explain how STIs cannot be transmitted, i.e., casual contact, toilet seats, eating utensils, coughing.
5. Explain that there are no vaccines against STIs and that there is no immunity to STIs. List curable and incurable STIs. Stress the importance of early treatment.
6. Explain that infection is dependent upon behavior, not on race, age, or social status.
7. Describe how the body is affected.
8. List symptoms of infection and how long it may take for symptoms to appear.
9. List complications that may result if infection is not treated.
10. Review the actions to take when exposed to an STI.

STI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family/partner will receive written information about sexually transmitted infections.

STANDARDS:

1. Provide the patient/family with written patient information literature on sexually transmitted infections.
2. Discuss the content of the patient information literature with the patient/family.

STI-M MEDICATION

OUTCOME: The patient/family/partner will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated. Explain that medications may cure bacterial STIs but typically provide only symptomatic relief for viral STIs.
2. Emphasize the importance of full participation with medication regimen.
3. Discuss the mechanism of action as needed.
4. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications. Emphasize the importance of informing the provider of any allergies or the potential for pregnancy.
5. Emphasize the importance of providing a list of all current medications, including non-prescription, complementary medicine or traditional remedies, to the provider.
6. Explain that in most cases, the patient's partner(s) will need to be treated. Describe the treatment regimen as appropriate.

STI-P PREVENTION

OUTCOME: The patient/family/partner will plan behavior patterns which will prevent STI infections.

STANDARDS:

1. List behaviors that eliminate or decrease risk of infection, i.e., use of latex condoms, use of spermicide with condom, monogamy, abstinence, not injecting drugs. Non-latex condoms, while not as effective as latex, are recommended when latex sensitivity is an issue.
2. Describe behavior changes which prevent transmission of STIs.
3. Discuss proper application of a condom.
4. Describe type of lubricant to use with condom, i.e., water-based gels, such as K-Y, Astroglide, Foreplay.
5. Describe how alcohol/substance use and/or abuse can affect ability to use preventive measures.

STI-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in sexually transmitted infections.

STANDARDS:

1. Explain that uncontrolled stress is linked with an increased recurrence of symptomatic outbreaks with many sexually transmitted infections, such as genital herpes and human papilloma virus.
2. Explain that effective stress management may help reduce the frequency of outbreaks, as well as help improve the patient's health and well-being.
3. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals in small attainable increments
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation or prayer
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
4. Provide referrals as appropriate.

STI-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed including indications and its impact on further care.

STANDARDS:

1. Explain the test ordered and any special preparatory information, such as first morning void versus not voiding prior to test.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
3. Explain the meaning of test results.

STI-TX TREATMENT

OUTCOME: Patient and partner will understand their treatment plan.

STANDARDS:

1. Emphasize the importance of early detection and treatment.
2. Stress the importance of treatment of the partner to prevent re-infection and spread of the infection.
3. Discuss the patient's specific treatment plan.
4. Discuss the importance of routine follow-up and testing as appropriate.

SHI—Shingles

SHI-C COMPLICATIONS

OUTCOME: The patient or family will understand common complications of shingles.

STANDARDS:

1. Explain that when the nerves to the eyes or face are affected, they may be at increased risk for developing post-herpetic neuralgia or PHN.
2. Discuss that shingles injures the peripheral nerves, causing pain, which may continue long after the rash has healed.
3. Explain that PHN causes the skin to become unusually sensitive to clothing, to a light touch, even to temperature.
4. Explain that if the virus invades an opthalmic nerve it can cause painful eye inflammations that can impair the vision.
5. Explain if shingles appear on the face and affects the auditory nerves, it can lead to complications in hearing.
6. Explain that infections of facial nerves can lead to temporary paralysis.
7. Explain that shingles sometimes develops a secondary infection that may result in scarring.

SHI-DP DISEASE PROCESS

OUTCOME: The patient/family will understand shingles and recognize its symptoms.

STANDARDS:

1. Explain that shingles (or herpes zoster) is a reactivation of a childhood chickenpox infection. However, instead of covering large parts of the body, the skin rash usually appears on a small area of skin, in rows like shingles on a roof.
2. Discuss symptoms of shingles:
    a. Burning, tingling, or numbness of the skin.
    b. Flu like symptoms such as fever, chills, upset stomach or headache
    c. Fluid-filled blisters
    d. Skin that is sensitive to touch
    e. Mild itching to extreme and intense pain
3. Explain that a typical shingles rash follows the path of certain nerves on one side of the body, generally on the trunk, buttocks, neck, face or scalp, and usually stops at midline.
4. Discuss the cause of reactivation is usually unknown, but seems to be linked to aging, stress, trauma or an impaired immune system.
5. Explain that contact with Shingle lesions can Chicken Pox in a non-immune person.

SHI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointment.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that follow-up appointments should be kept.
4. Explain signs or symptoms that would prompt immediate follow-up, i.e., redness, purulent discharge, fever, increased swelling or pain.

SHI-L PATIENT INFORMATION LITERATURE

OUTCOME: The parent(s) and family will receive written information shingles

STANDARDS:

1. Provide the parent(s) and family with written information about shingles
2. Discuss the content of the patient information literature with the parent(s) and family.

SHI-M MEDICATIONS

OUTCOME: The patient and/or family will understand the goals of drug therapy, the side effects of the medications and the importance of taking medications as prescribed.

STANDARDS:

1. Review the mechanisms of action for the patient's medication.
2. Discuss the proper use, benefits and common or important side effects of the patient's prescribed medications. Review signs of possible medication toxicity as indicated.
3. Emphasize the importance of taking medications as prescribed.

SHI-PM PAIN MANAGEMENT

OUTCOME: The patient will understand actions that may be taken to control pain from shingles.

STANDARDS

1. Explain that after the rash goes away, some people may be left with long lasting pain called post-herpetic neuralgia (PHN). Usually PHN pain will get better with time.
2. Explain that PHN pain is the longest lasting and worst part of shingles and needs to be discussed with the medical provider. There are a number of medications that can be prescribed to help relieve the pain. In addition, alternative approaches such as acupuncture, biofeedback and hypnotherapy can be beneficial.
3. Discuss that prolonged pain can cause depression, anxiety, sleeplessness, and weight loss and interfere with activities of daily living. Encourage the patient to discuss any of these problems with a provider. Explain that there are medicines that may help.
4. Explain the need to do things that take mind off pain, i.e., watch TV, read, talk with friends, or work on a hobby, share feelings about pain with family and friends, ask for help.

SHI-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in the treatment Shingles.

STANDARDS:

1. Discuss that uncontrolled stress may increase alcohol and other drug use and interfere with treatment.
2. Emphasize the importance of seeking professional help as needed to reduce stress.
3. Discuss the various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. Becoming aware of your own reactions to stress
    b. Recognizing and accepting your limits
    c. Talking with people you trust about your worries or problems
    d. Setting realistic and meaningful goals
    e. Getting enough sleep
    f. Making healthy food choices
    g. Regular physical activity
    h. Taking vacations
    i. Practicing meditation
    j. Self-hypnosis
    k. Using positive imagery
    l. Practicing relaxation methods such as deep breathing or progressive muscular relaxation
    m. Spiritual or cultural activities.
4. Provide referrals as appropriate

SHI-TX TREATMENT

OUTCOME: The patient and/or family will understand the possible treatment for shingles.

STANDARDS:

1. Discuss that in most cases shingles resolve on their own without specific treatment.
2 Explain that there are many medications that can be prescribed to treat shingles when symptoms are severe. These include medicines that:
    a. Fight the virus – antiviral drugs
    b. Lessen pain and shorten the time you're sick – steroids
    c. Reduce pain – analgesics.
3. Explain that when started within 72 hours of getting the rash, these medicines help shorten the length of the infection and lower the risk of other problems.
4. Explain that cool wet compresses can be used to reduce pain. Soothing baths and lotions, such as colloidal oatmeal bath or lotions and calamine lotion, may help to relieve itching and discomfort.
5. Discuss other things that may help to feel better including adequate rest, eating healthy meals and avoiding stress as much as possible. Try to relax. Stress can make the pain worse.

SWI—Skin and Wound Infections

SWI-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications associated with skin and wound infections.

STANDARDS:

1. Review with the patient/family the symptoms of a generalized infection, i.e., high fever spreading redness, red streaking, increased tenderness, changes in mental status, decreased urine output.
2. Review with the patient/family the effects of uncontrolled skin or wound infections (i.e., cellulitis) or generalized infection, i.e., loss of limb, need for facsiotomy and skin grafting, multi-organ failure, death.
3. Inform patient/family that scarring and/or tissue discoloration may develop after healing of the wound.
4. Emphasis the importance of early treatment to prevent complications.

SWI-DP DISEASE PROCESS

OUTCOME: The patient/family will understand cause and risk factors associated with skin and wound infections.

STANDARDS:

1. Review the current information regarding the causes and risk factors of skin and wound infections.
2. Explain how breaks in the skin can allow bacteria to enter the body.
3. Discuss importance of daily hygiene and skin inspection.
4. Explain that minor wounds should be kept clean and treated early to prevent serious skin or wound infections.
5. Explain, as appropriate, that the use of immunosuppressive or corticosteroid medication may increase the risk for skin and wound infections.
6. Explain, as appropriate, that elevated blood sugar increases the risk of serious skin and wound infections and impedes healing.
7. Review, as appropriate, peripheral vascular disease and/or ischemic ulcers as appropriate. **Refer to PVD.**
8. Discuss with the patient/family the pathophysiologic process of an inflammatory response.

SWI-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

SWI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointment.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that follow-up appointments should be kept.
4. Explain signs or symptoms that would prompt immediate follow-up, i.e., redness, purulent discharge, fever, increased swelling or pain.

SWI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about skin and wound infections.

STANDARDS:

1. Provide patient/family with written patient information literature.
2. Discuss the content of the patient information literature with the patient/family.

SWI-M MEDICATION

OUTCOME: The patient/family will understand the importance of full participation with the prescribed medication regimen.

STANDARDS:

1. Discuss reason for specific medication in treatment of this patient's infection.
2. Review directions for use and duration of therapy.
3. Discuss expected benefits of therapy as well as the important and common side effects. Discuss side effects that should prompt a return visit.
4. Discuss importance of full participation with medication regimen and how completion of an antibiotic course will help prevent the development of antibiotic resistance.
5. Emphasize the importance of follow-up.

SWI-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Discuss non-pharmacologic measures that may be helpful with pain control.

SWI-P PREVENTION

OUTCOME: The patient/family will understand the appropriate measures to prevent skin and wound infections.

STANDARDS:

1. Discuss avoidance of skin damage by wearing appropriate protective equipment (i.e., proper footwear, long sleeves, long pants, gloves), as appropriate.
2. Explain importance of good general hygiene and cleaning any breaks in the skin and observing for infections. **Refer to WL-HY**.
3. Review importance of maintaining good general health and controlling chronic medical conditions, especially glycemic control in diabetes. **Refer to DM-FTC.**

SWI-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

SWI-WC WOUND CARE

OUTCOME: The patient/family will understand the necessity and procedure for proper wound care and infection control measures. As appropriate they will demonstrate the necessary wound care techniques.

STANDARDS:

1. Explain the reasons to care appropriately for the wound, i.e., decreased infection rate, improved healing.
2. Explain the correct procedure for caring for this patient's wound.
3. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained
4. Emphasize the proper methods for disposal of used supplies.
5. Emphasize the importance of follow-up.
6. Discuss any special recommendations or instructions particular to the patient's wound.

ST—Strep Throat

ST-C COMPLICATIONS

OUTCOME: The patient/family will be able to relate the possible complications, the symptoms that should be reported immediately, and the appropriate actions to prevent complications.

STANDARDS:

1. Discuss the possible complications of untreated strep throat, i.e., rheumatic fever or glomerulonephritis.
2. List the symptoms that should be reported immediately, i.e., drooling, difficulty swallowing, blood in the urine, joint pains, abnormal movements and fever lasting longer than 48 hours after starting antibiotic.
3. Stress importance of follow-up appointment as appropriate.

ST-DP DISEASE PROCESS

OUTCOME: The patient will understand that strep throat may be a serious disease if left untreated.

STANDARDS:

1. Review ways in which strep throat can be spread to others in the family including family pets, i.e., eating or drinking after others, direct contact with secretions.
2. Explain that any child or adult in the home who has a fever, sore throat, runny nose, vomiting, and headache or develops these symptoms in the next five days should seek medical care.
3. Discuss that chronic or recurrent strep throat or rheumatic fever in a family member should prompt throat culture of all family members.
4. Discuss that strep throat is caused by a bacterium called *Streptococcus Pyogenes*. Explain that this bacterium may cause long term complications especially if untreated. **Refer to ST-C.**

ST-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of fully participating in the treatment regimen and keeping appointments for follow-up.

STANDARDS:

1. Discuss the patient's responsibility in the treatment of the strep throat.
2. Explain the procedure for making follow-up appointments.
3. Review the treatment plan with the patient/family, emphasizing the need for follow-up appointment and fully participating in the medication plan.

ST-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about strep throat.

STANDARDS:

1. Provide patient/family with written patient information literature on strep throat.
2. Discuss the content of patient information literature with the patient/family.

ST-M MEDICATIONS

OUTCOME: The patient will understand the importance of following the prescribed medication regimen.

STANDARDS:

1. Review proper use, benefit and common side effects of the prescribed medication.
2. Emphasize the importance of maintaining full participation in the medication regiment, i.e., take all the medication even if the symptoms are no longer present.
3. Explain that failure to complete the entire course of antibiotics increases the patient's risk of developing rheumatic heart disease and rheumatic fever as well as the risk of developing resistant bacteria.

ST-P PREVENTION

OUTCOME: The patient/family will understand the measures necessary to prevent the spread of strep throat.

STANDARDS:

1. Explain the importance of good hygiene and infection control principles to prevent the spread of strep infection.
2. Stress the importance of good hand washing.

ST-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand some ways to control pain associated with strep throat.

STANDARDS:

1. Discuss pain management techniques with the patient/family, i.e., gargling salt water, throat lozenges, and other medications as appropriate.

ST-TE TESTS

OUTCOME: The patient will understand the test to be performed and the reason for testing.

STANDARDS:

1. Explain the test used to diagnose strep throat, i.e., throat culture or rapid strep test.
2. Explain the indications and benefits of the test.
3. Explain the test as it relates to the diagnosis and treatment of strep throat.

SIDS—Sudden Infant Death Syndrome

SIDS-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

SIDS-I INFORMATION

OUTCOME: Parents/Family will understand what SIDS is and factors that are associated with increased risk of SIDS.

STANDARDS:

1. Explain that SIDS stands for Sudden Infant Death Syndrome. It is the sudden and unexplained death of a baby under 1 year of age. Most SIDS deaths happen between 2 and 4 months of age, occur during colder months, and more likely to be boys than girls.
2. Explain that because many SIDS babies are found in their cribs, some people call SIDS "crib death." But, cribs do not cause SIDS.
3. Explain that the cause of SIDS remains unknown. SIDS is unique, because, by definition its major presenting symptom is unexplained death. The diagnosis is based entirely on what is not found. SIDS is, in other words, a diagnosis of exclusion.
4. Emphasize that although the incidence of SIDS is on the decline in the US, the rate of SIDS highest among Native Americans and Alaska Natives.
5. Explain that several important factors are associated with an increased risk of SIDS. These factors are prone (stomach) and side infant sleeping positions, exposure of infants to cigarette smoke and potentially hazardous sleeping environments.

SIDS-L PATIENT INFORMATION LITERATURE

OUTCOME: The parent(s) and family will receive written information about Sudden Infant Death Syndrome.

STANDARDS:

1. Provide the parent(s) and family with written information about SIDS.
2. Discuss the content of the patient information literature with the parent(s) and family.

SIDS-P PREVENTION

OUTCOME: The parents and/or family will understand the factors associated with an increased risk of SIDS and how to lower the risk of SIDS and prevent problems.

STANDARDS

1. Explain that placing your baby on his or her back to sleep, even for naps, is the safest sleep position for a healthy baby and has been proven to reduce the risk of SIDS. "Back is best" from a SIDS risk-reduction point of view. There is no evidence of increased risk of choking or other problems associated with healthy infants sleeping on their backs.
2. Explain that the stomach sleeping position is associated with the highest risk of SIDS. Side lying position falls in between and babies who sleep on their sides can roll onto their stomach and have an increased risk of SIDS.
3. Explain that when a baby sleeps only in the back position, some flattening of the back of the head may occur. Flat spots on the back of the head are not harmful or associated with any permanent effects on head size and go away a few months after the baby learns to sit up.
4. Discuss that specialists recommend changing the baby's head position during sleep to minimize the effects on head shape. One way to do this is to alternate the head of the bed to the foot of the bed on alternate nights. That is, place the baby's head on different ends of the bed on different nights with the face always facing the inside of the room.
5. Explain that "tummy time" is important. An infant can safely be placed on his or her tummy when he/she is awake and someone is watching. This is important for infant development and will help make neck and shoulder muscles stronger.
6. Explain that there is no evidence that infant home monitoring can prevent SIDS. Physicians may recommend monitors in some special circumstances.
7. Discuss that the greatest majority of infants dying of SIDS are apparently healthy infants who do not meet the criteria for home monitoring.
8. Discuss that other sleep behaviors are associated with a higher than average rate of SIDS deaths; (co-sleeping, fluffy materials in the bed with the infant, waterbed sleeping, sleeping in the same bed with other persons, overheating during sleep.
9. Discuss that alcohol use in the first trimester of pregnancy is associated with increased risk of SIDS death.
10. Explain that infants who sleep in homes where smoking occurs inside the home are at a greatly increased risk of dying of SIDS compared to infants who sleep in homes where no one ever smokes in the home.
11. Encourage the client to be receptive to home visits by public health nurses as this has been associated with a lower risk of SIDS deaths.

SIDS-S SAFETY AND INJURY PREVENTION

OUTCOME: The parents/family will understand that even though there is no way to know which babies might die of SIDS, there are some measures that can be taken to make their baby safer.

STANDARDS:

1. Discuss that placing a baby to sleep on soft mattresses, sofa cushions, waterbeds, sheepskins, or other soft surfaces can increase the risk of SIDS, possibly by increasing the risk of carbon dioxide rebreathing (asphyxiation).
2. Emphasize firm bedding, Discourage the use of pillows, loose bedding, crib bumpers, fluffy blankets and stuffed toys in the baby's sleep area. Make sure baby's face and head stays uncovered during sleep.
3. Discuss potential hazards of overheating. Don't let baby get too warm during sleep. Babies should be lightly dressed and covered with a sheet or thin blanket, and the room temperature should be comfortable. The current recommendation is for no more than two layers of clothing during sleep.
4. Discuss that there are hidden hazards in letting babies sleep on adult beds, including falls, suffocation, and getting trapped between the bed and wall, the head board, and foot board. Beds are not designed to meet safety standards for infants and carry risk of accidental entrapment and suffocation.
5. Explain that it is currently believed that the safest place for an infant to sleep is in a crib with a firm mattress. Sleeping alone, with no other person in the bed is recommended. Infants sleeping in adult beds are at increase risk of suffocation.

SIDS-SHS SECOND-HAND SMOKE

OUTCOME: The patient and/or family will understand the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting babies' exposure to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. smoldering cigarette, cigar or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets, or walls.
2. Discuss harmful substances in smoke
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances).
3. Discuss that tobacco smoke increases the risk of SIDS and it appears to be related to the "dose" of passive-smoke exposure - - the greater the exposure to smoke both before and after birth, the higher the risk of SIDS.
4. Explain that smoking anywhere in the home may increase the risk, so just going into another room to smoke is not sufficient. Smoke gets trapped in carpets, upholstery, and clothing. Parents should keep the baby in a smoke-free environment.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage and offer smoking cessation or at least never smoking in the home or car.
7. **Refer to TO**.

SB—Suicidal Behavior

SB-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

SB-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

SB-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about suicidal behavior.

STANDARDS:

1. Provide the patient/family with written patient information literature on suicidal behavior.
2. Discuss the content of patient information literature with the patient/family.

SB-PSY PSYCHOTHERAPY

OUTCOME: The patient will understand the goals and process of such therapy.

STANDARDS:

1. Emphasize that for the process of psychotherapy to be effective the patient must keep all appointments. Emphasize the importance of openness and honesty with the therapist.
2. Explain to the patient/family that the therapist and the patient will jointly establish goals, ground rules, and duration of therapy.

SB-SCR SCREENING

OUTCOME: The patient/family will understand the screening device.

STANDARDS

1. Explain the screening device to be used.
2. Explain why the screening is being performed.
3. Discuss how the results of the screening will be used.
4. Emphasize the importance of follow-up care.

SB-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in suicidal behaviors.

STANDARDS:

1. Explain that uncontrolled stress is linked with the onset of major depression and contributes to more severe symptoms of depression.
2. Explain that uncontrolled stress can interfere with the treatment of suicidal behaviors.
3. Explain that effective stress management may reduce the severity of symptoms the patient experiences, as well as help improve the health and well-being of the patient.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all of which can increase the severity of the depression and increase risk of suicidal behaviors.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

SB-TX TREATMENT

OUTCOME: The patient/family will have a basic understanding of the short and long term goals and expected result of treatment.

STANDARDS:

1. Reassure the patient. Reinforce the fact that the patient is not alone and that he/she can be helped.
2. Discuss options for treatment, both short-term and long-term.
3. Discuss that there may be an initial crisis stabilization period followed by a longer period of psychotherapy and lifestyle adjustments.

SB-WL WELLNESS

OUTCOME: The patient/family will understand some of the factors which contribute to a balanced and healthy lifestyle.

STANDARDS:

1. Explain that a healthy diet is an important component of behavioral and emotional health. **Refer to WL-N.**
2. Emphasize the importance of stress reduction and exercise in behavioral and emotional health.
3. Explain that behavior and emotional problems often result from unhealthy patterns of social interaction. Help to identify supportive social networks.
4. Emphasize that use of alcohol and/or other drugs of abuse can be extremely harmful to behavioral and emotional health. **Refer to AOD.**
5. Emphasize that behavioral and emotional problems often co-exist with domestic violence. Encourage the patient to use local resources as appropriate. **Refer to DV.**
6. Explain other ways the patient can help him/herself feel better:
    a. Talk to someone you trust.
    b. Try to figure out the cause of your worries.
    c. Understanding your feelings will help you see other ways for dealing with your anger or depression.
    d. Write down a list of good things you have done. Remember them and even read the list out loud to yourself when you feel bad.
    e. Do not keep to yourself; being with other people that support and encourage you as much as possible.
    f. **In an emergency or during a crisis call 9-1-1** or other emergency access numbers or crisis hotlines.

SUN—Sun Exposure

SUN-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications associated with excessive sun exposure.

STANDARDS

1. Explain that UVB causes sunburn and plays a significant role in superficial skin cancers called basal cell carcinomas and squamous cell carcinomas.
2. Discuss the 4 ABCD warning signs of malignant melanoma:
    a. Asymmetry – one half of the mole or lesion differs from the other half
    b. Border – The border of the mole or lesion is irregular, scalloped or underlined
    c. Color – Color varies from one area to another within the mole or lesion
    d. Diameter – The mole or lesion is larger than 6mm across – about the size of a pencil eraser
3. Explain that sunburns before the age of 18 are more likely to cause skin cancers later on in life.
4. Explain that excessive sun exposure causes premature aging of the skin.
5. Explain that dehydration and pain are common complications of sunburn.
6. Explain that secondary infections may result from sunburns that blister and peel.

SUN-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of overexposure to the sun or other UV radiation/light.

STANDARDS:

1. Explain that the two types of ultraviolet radiation – ultraviolet A (UVA) and ultraviolet B (UVB) – have an effect on your skin and can impair your skin's DNA repair system which may contribute to cancer.
2. Explain that UVA usually causes the leathery, sagging, brown-spotted skin of those who spend a lot of time in the sun. UVA can also penetrate window glass, including car windows. Tanning beds are a source of high doses of UVA.
3. Explain that sunburn is the result of overexposure to the sun's ultraviolet (UV) radiation. Repeated exposure to UV radiation both tans and damages your skin. The signs and symptoms of sunburn usually appear within a few hours of exposure, bringing pain, redness, swelling and occasional blistering. Because sun burn often affects a large area of your skin, sunburn can cause headache, fever and fatigue.
4. Explain that the first step is to determine the degree and the extent of damage to body tissues. Damage from the sun is usually limited to first and second degree burns:
    a. First-degree burns are those in which only the outer layer of skin (epidermis) is burned. The skin is usually red, with swelling and pain sometimes present. The outer layer of skin hasn't been burned through. Treat a first degree burn as a minor burn unless it involves substantial portions of the hands, feet, face, or other large areas of the body.
    b. Second-degree burns are when the first layer of skin has been burned through and the second layer of skin (dermis) also is burned. Blisters develop and the skin takes on an intensely reddened, splotchy appearance. Second-degree burns produce severe pain and swelling.

SUN-I INFORMATION

OUTCOME: Parents/Family will understand sunburns; and the factors that are associated with increased risk of sunburn.

STANDARDS:

1. Explain that the UV content of sunlight varies. It's greater at higher elevations because it is unfiltered by clouds or haze. But reflected UV light also comes from snow, sand, water and other highly reflective surfaces and can burn as severely as direct sunlight. You can also get sunburn on a cloudy day
2. Explain that protection from the sun is very important in the prevention of skin cancer. Protective steps should begin in early childhood. Regular, proper use of broad-spectrum sunscreens such as those that offer protection from both UVA and UVB radiation is the key in preventing sunburn, sun damage and skin cancer.
3. Explain that regardless of skin pigmentation, all people are at risk for sun damage to their skin and should wear sunscreen.

SUN-L PATIENT INFORMATION LITERATURE

OUTCOME: The parent(s) and family will receive written information appropriate to the type and degree of the sunburn.

STANDARDS:

1. Provide written information about first and second-degree burns that are the result of over-exposure to the sun.
2. Discuss the content of the patient information literature.

SUN-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle adaptations necessary to prevent complications of sunburn.

STANDARDS:

1. Review lifestyle aspects/changes that the patient has control over, such as:
    a. Consistent use of a sunscreen each and every day
    b. Discuss the importance of infants, children and youth using a sunscreen. Explain that sunburns before the age of 18 are more likely to cause skin cancers later on in life.
    c. Avoid the use of tanning beds
    d. Limit outdoor exposure to early morning or late afternoon. Sunlight is strongest from 11am-2pm.
    e. Wear appropriate clothing to cover the body, i.e., long sleeved shirts and wide brimmed hats.

SUN-P PREVENTION

OUTCOME: The patient/family will understand the factors associated with an increased risk of sunburns and how to lower the risk of sunburn and prevent complications.

STANDARDS

1. Explain that protection from the sun is very important in the prevention of skin cancer. Protective steps should begin in early childhood. Regular, proper use of broad-spectrum sunscreens such as those that offer protection from both UVA and UVB radiation is the key in preventing sunburn, sun damage and skin cancer.
2. Explain that when purchasing sunscreens, it is important to check the label to ensure that the product is a broad spectrum sunscreen offering both UVA and UVB protection. Sunscreen advertisements such as total sunblock, waterproof, all-day protection and deep-tanning are mis-leading as they do not necessarily offer both UVA and UVB protection. Read sunscreen labels carefully for UVA and UVB protection.
3. Explain that the Sun Protection Factor (SPF) ratings are based on how much longer someone may be protected from sunburn than he or she is if no sunscreen were applied. For example, if you normally burn in 20 minutes, a product with SPF 15 may allow you to stay out in the sun 15 times longer, if properly applied. The minimum level of SPF purchased should be SPF 15.
4. Explain that most people use sunscreens too sparingly. A liberal application is 1 ounce – two tablespoons full – to cover exposed parts of the body.
5. Explain that the timing of sunscreen application is also important. To have the best effect, sunscreens need to be applied 30 minutes before any outdoor activities– not after you go out.
6. Explain that because of sweating, swimming and toweling off, sunscreen should be reapplied throughout the day. Even water-resistant sunscreens need to be reapplied every 90 minutes.
7. Discuss the need to avoid using tanning beds. There is no such thing as a safe tan. Tanning beds aren't safe, and they may cause skin cancer. While tanning salons may advertise that they use only UVA light, research doesn't support VUA being "good" and UVB – as being "bad." Both UVA and UVB may increase the risk of skin cancer or melanoma.
8. Explain that if a tan is desired, consider use of one of the many "bronzers" available at cosmetic counters. Patients using "bronzers" must be reminded that they must still use a sunscreen over their "bronzer" as bronzers usually do not contain sunscreens.
9. Discuss ways in which the patient can protect themselves from the sun regardless of whether you are in the sun for work or play.
10. Explain that regardless of skin pigmentation, all people are at risk for sun damage to their skin and should wear sunscreen.

SUN-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient will understand that precautions should be taken every day to avoid over exposure to UVA and UVB sunlight.

STANDARDS:

1. Discuss the consistent use of a sunscreen each and every day.
2. Discuss the added importance of infants, children and youth using a sunscreen.
3. Remind patient/family to avoid the use of tanning beds.
4. Emphasize outdoor exposure during the 11am-2pm time period should be limited.

SUN-TX TREATMENT

OUTCOME: The patient/family will understand the importance of treating the discomforts of sunburn and when to seek appropriate medical care.

STANDARDS:

1. Explain that exposure to large areas of the skin can result in headache, fever, fatigue, and dehydration.
2. Explain that if you have a sunburn:
   a. Take a cool bath or shower
   b. Apply an aloe vera lotion several times a day
   c. Leave blisters intact to speed healing and avoid infection. If they burst, apply an antibacterial ointment on the open areas and cover with a sterile gauze bandage.
3. Explain, if needed, for discomfort take a mild over-the-counter analgesic.
4. Encourage consumption of water or other non-caffeinated beverages.
5. Explain that severe sunburn may require and benefit from medical attention.
6. Encourage the patient to be smart about sun exposure:
   a. wear a broad-brimmed hat and light-colored clothing that covers your exposed skin
   b. use a broad-spectrum sunscreen
   c. limit outdoor sports and other activities to the early morning or late afternoon whenever possible.
   d. wear UVA and UVB rated sunglasses
7. Explain that the use of alcohol and other drugs may impair sound judgment when participating in outdoor activities. Caution should be exercised in combining the use of alcohol and other drugs with outdoor activities.
8. Refer to **BURN**.

T

TO—Tobacco Use

It is important to screen tobacco use and to record the responses appropriately in the Health Factors. Listed below are the definitions for tobacco use:

- Non-Tobacco Use – *Never* used *any* tobacco products
- Current Smoker – Smokes. Ask number of cigarettes/packs smoked per day
- Current Smokeless – Uses smokeless. Ask number of Cans/plugs per day
- Cessation Smoker – Former smoker, now quit. Document Quit Date _____
- Cessation Smokeless – Former smokeless user, now quit. Document Quit date____
- Previous Smoker – Smoker who smoked for ____years. Now Quit.
- Previous Smokeless – Smokeless user for ___ years. Now Quit.
- Non-Smoker but smoker in home, i.e., exposed to second hand smoke
- Environmental Exposure – Works in environment (casino, Bingo) with exposure to smoke.
- Ceremonial/Traditional use of tobacco

TO-C COMPLICATIONS

OUTCOME: The patient/family will understand how to avoid the slow progression of disease and disability resulting from tobacco use.

STANDARDS:

1. Discuss the common problems associated with tobacco use and the long term effects of continued use of tobacco, i.e., COPD, cardiovascular disease, numerous kinds of cancers including lung cancer.
2. Review the effects of tobacco use on all family members- financial burden, second-hand smoke, asthma, greater risk of fire, early death of a bread-winner.
3. Discuss the possible implications of tobacco use on newborns, infants and children, as well as being a possible link to SIDS.

TO-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

TO-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the slow progression of disease and disability associated with tobacco use.

STANDARDS:

1. Review the current factual information regarding tobacco use. Explain that tobacco use in any form is dangerous.
2. Explain nicotine addiction.
3. Explain dependency and co-dependency.

TO-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in this patient's disease process and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
2. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
3. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
4. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
5. Discuss medical clearance issues for physical activity.

TO-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

TO-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about tobacco use or cessation of use.

STANDARDS:

1. Provide the patient/family with written patient information literature on tobacco use or cessation of use.
2. Discuss the content of the patient information literature with the patient/family.

TO-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will see tobacco abstinence as a way of life.

STANDARDS:

1. Discuss the patient's use/abuse of tobacco.
2. Discuss tips for stress relief and healthy "replacement habits".
3. Discuss the difference between recreational use of tobacco versus traditional or ceremonial use of tobacco.

TO-M MEDICATIONS

OUTCOME: If applicable, the patient/family will understand the importance of fully participating with a prescribed medication regimen.

STANDARDS:

1. Review the proper use, benefits and common side effects of the prescribed medication.
2. Briefly review the mechanism of action of the medication if appropriate.
3. Explain that medications can help only if the patient is ready to quit and that medications work best in conjunction with counseling and lifestyle-modification education.
4. Explain that some medications may not work right away but will require a few days to a few weeks to take effect.
5. Emphasize that there may be dangers in using medications in conjunction with smoking and that some medications may be addictive, so it is important to have a dose-tapering regimen and keep to it.

TO-QT QUIT

OUTCOME: The patient/family will understand that smoking is a serious threat to their health, that they have been advised by health professionals to quit, and how participation in a support program may prevent relapse.

STANDARDS:

1. Discuss the importance of quitting tobacco use now and completely.
2. Establish a quit date and plan of care.
3. Review the treatment and support options available to the patient/family.
4. Review the value of close F/U and support during the first months of cessation.

TO-RTC READINESS TO CHANGE

OUTCOME: The patient/family will understand

STANDARDS

RTC 1 The patient has no interest in making the recommended change. Precontemplation (Ready in more than 6mos)

RTC 2 The patient has begun to show interest in making the recommended change. Contemplation (Ready in 1-6 mo)

RTC 3 The patient is beginning to make preparations to make the change. Preparation (Ready in 30 days or less)

RTC 4 The patient is actively making a change. Action (Quitting 0-6mo)

RTC 5 The patient has continued to Maintenance (quit for at least 6 months or more)

TO-SCR SCREENING

OUTCOME: The patient/family will understand the screening device.

STANDARDS

1. Explain why the screening is being performed.
2. Discuss how the results of the screening will be used.
3. Emphasize the importance of follow-up care.

TO-SHS SECOND-HAND SMOKE

OUTCOME: Provide the patient and/or family with an understanding of the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls.
2. Discuss harmful substances in smoke
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness in people who are exposed to cigarette smoke either directly or via second-hand smoke. Explain that this risk is even higher for people with pulmonary diseases like COPD or asthma.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Discuss not smoking around infants and children, including in the home and in the car. Second hand smoke increases the risk of SIDS. Encourage smoking cessation.

TO-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in tobacco abuse and its effect on tobacco cessation.

STANDARDS:

1. Discuss that uncontrolled stress may increase tobacco use and interfere with tobacco cessation.
2. Explain that uncontrolled stress can interfere with the treatment of tobacco addiction.
3. Discuss that uncontrolled stress may exacerbate adverse health behaviors such as increased alcohol or other substance use, all of which can increase tobacco use and interfere with tobacco cessation.
4. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
5. Provide referrals as appropriate.

TB—Tuberculosis

TB-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

TB-DOT DIRECTLY OBSERVED THERAPY

OUTCOME: The patient/family will understand the importance of fully participating with a prescribed medication regimen using the directly observed therapy (DOT) regimen for TB.

STANDARDS:

1. Provide a pill count.
2. Discuss the use, benefits, and common side effects of prescribed medications.
3. Discuss the patient's full participation / non-participation. Discuss the consequences of non-participation.
4. Discuss the procedure for DOT.

TB-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the etiology, pathophysiology, and communicability of tuberculosis infection.

STANDARDS:

1. Review the anatomy and physiology of the affected system, i.e., respiratory, lymphatic.
2. Review hygiene and infection control as it relates to TB.
3. Explain the patient's specific disease process.
4. Explain the most common complications of the disease process.

TB-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

TB-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about tuberculosis.

STANDARDS:

1. Provide the patient/family with written patient information literature on tuberculosis.
2. Discuss the content of the patient information literature with the patient/family.

TB-M MEDICATIONS

OUTCOME: The patient/family will understand the medication regimen and the importance of full participation .

STANDARDS:

1. Discuss the use, benefits, and common side effects of prescribed medications.
2. Emphasize the importance of full participation and completion of therapy. Explain that drug resistance is increased by incomplete courses of therapy.
3. Discuss the consequences of non-participation.

TB-P PREVENTION

OUTCOME: The patient/family will understand communicability and preventive measures for TB.

STANDARDS:

1. Emphasize the importance of early detection and treatment of TB.
2. Discuss the mode of transmission and methods for reducing the risk of contracting TB, i.e., hand washing, covering the mouth when coughing or sneezing, disposing of contaminated materials.
3. Explain that patients with active TB must wear a mask until they have completed at least two weeks of treatment.
4. Review the actions to take when exposed to TB.

TB-PPD SCREENING SKIN TEST

OUTCOME: Patient/family will understand the importance of screening and follow-up and the meaning of the result.

STANDARDS:

1. Discuss the purpose, procedure, and meaning of the screening test and results if available.
2. Emphasize the importance of screening annually or on other schedule as appropriate.
3. Explain that a person who has reacted positively in the past will always react positively in the future and repeat testing may not be appropriate, or other types of testing may be indicated.

TB-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

U

UC—Ulcerative Colitis

UC-C COMPLICATIONS

OUTCOME: The patient/family will understand the signs of complications of ulcerative colitis and will plan to return for medical care if they occur.

STANDARDS:

1. Explain that some possible complications of ulcerative colitis are colon perforation, hemorrhage, toxic megacolon, abscess formation, stricture, anal fistula, malnutrition,, anemia, electrolyte imbalance, skin ulceration, arthritis, ankylosing spondylitis, and cancer of the colon.
2. Explain that complications may be delayed, minimized or prevented with prompt treatment of exacerbation.
3. Discuss the symptoms of exacerbation that trigger the need to seek medical attention, i.e., unusual abdominal pain, blood in stools, fever, weight loss, change in frequency of stools, joint pain.

UC-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

UC-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of their specific bowel disease.

STANDARDS:

1. Explain that ulcerative colitis is an inflammatory disease of the mucosa and, less frequently, the submucosa of the colon and rectum.
2. Explain that the exact cause of ulcerative colitis is unknown, but may be related to infection, stress, allergy, autoimmunity and familial predisposition.
3. Explain that this disease is most common during young-adulthood to middle life.
4. Explain that the symptoms are diarrhea, abdominal cramping, weight loss, anorexia, nausea, vomiting and abdominal pain.
5. Explain that ulcerative colitis is characterized by remissions and exacerbations.
6. Explain that careful medical management may eliminate/postpone the need for surgical intervention.

UC-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

UC-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the specific bowel disease.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding colon disease.
2. Discuss the content of the patient information literature with the patient/family.

UC-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication regimen and its importance.

STANDARDS:

1. Describe the proper use, benefits, and common or important side effects of the patient's medications. State the name, dose, and time for administration as applicable.
2. Discuss any significant drug/drug or drug/food interactions, including interaction with alcohol.
3. Discuss with the patient/family the need to complete the full course of antibiotics, as prescribed.
4. Caution the patient/family against utilizing over-the-counter medications for constipation without consulting his/her provider.

UC-N NUTRITION

OUTCOME: The patient/family will understand how dietary modification may assist in the control of bowel function and develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.
2. Advise the patient to avoid dairy products if the patient is lactose intolerant.
3. Encourage the patient/family to maintain a well-balanced, low-residue, high-protein diet.
4. Assist the patient/family to identify foods which cause irritation and encourage them to eliminate or minimize these in the diet.
5. Advise the patient to avoid cold or carbonated foods or drinks which increase intestinal motility.
6. Assist the patient/family in developing appropriate meal plans. Encourage frequent, small meals and chew food thoroughly.
7. Explain that supplementation with vitamins and minerals may be necessary.
8. Refer to dietitian as appropriate.

UC-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of colon disease.

STANDARDS:

1. Discuss the effects of a fatty, low fiber diet on the colon.
2. Provide and review a list of low fat, high fiber foods.
3. Assist the patient/family in meal planning that includes low fat, high fiber foods and avoids high fat, low fiber foods.
4. Explain that the etiology of Crohn's disease is unknown and there is no known prevention, but an appropriate diet may prevent or slow progression of the disease.

UC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Discuss the plan for sedatives and tranquilizers to provide, not only for rest, but to decrease peristalsis and subsequent cramping.
2. Instruct the patient in careful cleansing and protection of the perianal skin to provide comfort and prevent painful excoriation.
3. Explain that short term use of narcotics may be helpful in acute pain management.
4. Advise the patient not to use over the counter pain medications without checking with his/her provider.

UC-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in ulcerative colitis.

STANDARDS:

1. Explain that uncontrolled stress is linked with increased exacerbations of ulcerative colitis.
2. Explain that uncontrolled stress can interfere with the treatment of ulcerative colitis.
3. Explain that effective stress management may reduce the number of relapses, as well as help improve the patient's health and well-being.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use, all of which can increase the risk of morbidity and mortality from ulcerative colitis.
5. Explain that stress may cause inappropriate eating which will exacerbate the symptoms of ulcerative colitis. **Refer to UC-N.**
6. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
   a. becoming aware of your own reactions to stress
   b. recognizing and accepting your limits
   c. talking with people you trust about your worries or problems
   d. setting realistic goals
   e. getting enough sleep
   f. maintaining a reasonable diet
   g. exercising regularly
   h. taking vacations
   i. practicing meditation
   j. self-hypnosis
   k. using positive imagery
   l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   m. spiritual or cultural activities
7. Provide referrals as appropriate.

UC-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Proctosigmoidoscopy and Colonoscopy
    a. Explain that proctosigmoidoscopy and colonoscopy may be utilized to directly visualize the inside of the colon and enable biopsies to be obtained. The information from the colonoscopy may be necessary to diagnose the specific type of bowel disease.
    b. Explain that the procedure involves introducing a flexible tube through the anus and rectum.
    c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.
2. Upper gastrointestinal barium studies
    a. Explain that the upper GI barium study is an x-ray to assess the degree and extent of the disease.
    b. Explain that barium liquid will be swallowed and radiographs taken.
3. Barium Enema
    a. Explain that the barium enema is an x-ray to assess the extent of the disease, identify lesions, detect pseudo polyps, carcinoma, and strictures.
    b. Explain that barium liquid will be introduced by enema and radiographs taken.
    c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.

UC-TX TREATMENT

OUTCOME: The patient/family will understand the appropriate treatment for ulcerative colitis and have a plan to fully participate in the treatment regimen. The patient/family will further understand the risk/benefit ratio of the testing proposed as well as alternatives to testing and the risk of non-testing.

STANDARDS:

1. Discuss the specific treatment plan, which may include the following:
    a. Bedrest
    b. IV fluid replacement to correct dehydration
    c. Clear liquid diet, or in severe cases, parenteral hyperalimentation to rest the intestinal tract and restore nitrogen balance
    d. Sulfasalazine, for its antibacterial and anti-inflammatory effects
    e. Corticosteroids, systemically or by rectal instillation, to decrease inflammation
    f. Colectomy.
2. Discuss the risk/benefit ratio and alternatives to treatment as well as the risk of non-treatment.

URI—Upper Respiratory Infection

URI-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

URI-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of an upper respiratory tract infection.

STANDARDS:

1. Explain that URIs (colds) are caused by viruses and that antibiotics are not effective.
2. Discuss the basic anatomy of the upper respiratory system.
3. Discuss the factors that increase the risk for acquiring an upper respiratory infection, i.e., direct physical contact, children in school.
4. Discuss signs and symptoms of an upper respiratory infection, i.e., malaise, rhinorrhea, sneezing, scratchy throat.

URI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up if needed.

STANDARDS:

1. Discuss the importance of follow-up care, if needed. Explain that follow-up is usually only necessary if symptoms persist for greater than 2 weeks or if symptoms worsen.
2. Discuss the process for obtaining follow-up care and or appointment.
3. Emphasize that appointments should be kept.

URI-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand how to manage an upper respiratory infection at home.

STANDARDS:

1. Discuss the use of over the counter medications for symptom relief, i.e., decongestants, antihistamines, expectorants.
2. Discuss the use of non-pharmacologic therapies that may be useful in symptom relief, i.e., nasal lavage, humidification of room, increasing oral fluids.

URI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about upper respiratory infections.

STANDARDS:

1. Provide patient/family with written patient information literature on upper respiratory infection.
2. Discuss the content of patient information literature with the patient/family.

URI-M MEDICATIONS

OUTCOME: The patient/family will understand that antibiotics do not cure viral infections, and understand that some over-the-counter medications may be helpful in symptom reduction.

STANDARDS:

1. Discuss the use of over the counter medications, vitamin supplements and herbal remedies for symptom relief, i.e., decongestants, antihistamines, expectorants.
2. Explain that URIs (colds) are caused by viruses and that antibiotics are not effective.

URI-P PREVENTION

OUTCOME: The patient/family will have an understanding how to reduce the transmission of the common cold.

STANDARDS:

1. Discuss infection control measures, i.e., hand washing, reducing finger-to-nose contact, limiting exposure to the cold sufferer, proper handling and/or disposal of contaminated items.

UTI—Urinary Tract Infection

UTI-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand basic anatomy and physiology as it relates to UTIs.

STANDARDS:

1. Discuss the basic anatomy and physiology of the urinary tract as it relates to UTIs. As appropriate, discuss the difference between male and female anatomy.
2. As appropriate, discuss the role of foreskin in recurrent UTIs.

UTI-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of a urinary tract infection.

STANDARDS:

1. Discuss the basic anatomy and physiology of the urinary tract.
2. Discuss factors that increase the risk for developing a urinary tract infection, i.e., bladder outlet obstruction, hygiene factors, pelvic relaxation.
3. Discuss some signs and symptoms of urinary tract infection, i.e., dysuria, frequency, nocturia.

UTI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care, including test of cure as appropriate.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

UTI-HY HYGIENE

OUTCOME: The patient/family will understand how personal hygiene affects acquiring UTIs and prevention of UTIs.

STANDARDS:

1. Review the aspects of good personal hygiene as it relates to prevention of UTIs:
   a. Wipe only from anterior to posterior (front to back).
   b. Avoid bubble baths.
   c. Keep the perineal region clean.
2. Discuss the role of foreskin hygiene as appropriate.
3. Discuss, as appropriate, the role of sexual intercourse in acquiring UTIs.

UTI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about urinary tract infections.

STANDARDS:

1. Provide patient/family with written patient information literature.
2. Discuss the content of the patient information literature with the patient/family.

UTI-M MEDICATION

OUTCOME: The patient/family will understand their medication regimen and the importance of full participation with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications. **Refer to M**.
3. Discuss importance of full participation with the medication regimen in order to promote healing and assure optimal comfort levels.
4. Discuss the importance of completing the entire course of antibiotics to decrease the risk of development of resistant organisms.
5. Inform patient/family that kidney damage is irreversible and special care needs to be taken to reduce the risk of recurrent infections.

UTI-N NUTRITION

OUTCOME: The patient/family will understand the importance of a nutritionally balanced diet as related to UTIs.

STANDARDS:

1. Assess current nutritional habits and needs.
2. Emphasize the necessary component - WATER - in a healthy diet. Decrease consumption of colas and caffeinated beverages.

UTI-P PREVENTION

OUTCOME: The patient/family will understand precipitating factors for UTIs and will make a plan to minimize recurrence.

STANDARDS:

1. Discuss importance of fully participating in treatment plan.
2. Discuss the role of good hygiene in reducing the risk of UTIs.
3. Discuss the role of prophylactic medications in reduction of future UTIs as indicated.
4. Discuss other lifestyle factors that may help prevent UTIs, i.e., frequent urination, void after sexual intercourse, monogamy, drink plenty of water, eliminate bubble baths.

UTI-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM.**
2. Explain that medications may be helpful to control the symptoms of pain, nausea and vomiting as applicable.
3. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
4. Explain non-pharmacologic measures that may be helpful with pain control.

UTI-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in sexually transmitted infections.

STANDARDS:

1. Explain that uncontrolled stress is linked with an increased recurrence of symptomatic outbreaks with many sexually transmitted infections, such as genital herpes and human papilloma virus.
2. Explain that effective stress management may help reduce the frequency of outbreaks, as well as help improve the patient's health and well-being.
3. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals in small attainable increments
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation or prayer
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
4. Provide referrals as appropriate.

UTI-TE TESTS

OUTCOME: The patient/family will have basic understanding of the tests to be performed including indications, risks, benefits and consequences of non-intervention.

STANDARDS:

1. Explain the test ordered including indication(s), risks, benefits, information to be obtained and consequences of non-intervention.
2. Explain that the treatment decision will be made by the patient and medical team after reviewing the results of the diagnostic tests.
3. Explain any preparation that must be done prior to testing, i.e., NPO, have a full bladder, void prior to test.