

INDIAN HEALTH SERVICE

Patient and Family Education Protocols and Codes

9th Edition

June 2003

FOREWORD TO THE 9TH EDITION OF THE PATIENT EDUCATION PROTOCOLS

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 again thank Mary Wachacha, IHS Chief of Health Education. Without her vision (and financing) 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:

Michale Ratzlaff, M.D. or Kelton H. Oliver, M.D.
PEP-C
Northeastern Tribal Health Center
P.O. Box 1498
Miami, OK 74355
michale.ratzlaff@mail.ihs.gov or mratzlaff@pol.net or kelton@pol.net

Kelton Oliver, M.D. and Michale Ratzlaff, M.D.
Co-Chairs, National Patient Education Protocols Committee

FOREWORD TO THE 9TH EDITION OF THE PATIENT EDUCATION PROTOCOLS

The current membership of the National IHS Patient Education Protocols Committee:

Committee Co-Chair

CDR Kelton Oliver, M.D.
Senior Medical Officer, Family Practice
Northeastern Tribal Health Center (OK)

Cecilia Butler, R.D., L.D.
Dietician
Santa Fe Indian Hospital (NM)

CDR Susan Dethman, R.D., C.D.E.,
C.H.E.S.
Public Health Nutritionist
Wewoka IHS Clinic (OK)

Sande Hahn, R.N.
Public Health Nurse
Yakama Service Unit (WA)

LCDR Christopher C. Lamer, Pharm.D.
Pharmacist
Cherokee Service Unit (NC)

Committee Co-Chair

CDR Michale Ratzlaff, M.D.
Clinical Specialty Consultant, Pediatrics
Northeastern Tribal Health Center (OK)

Linda Lucke, R.N., B.S.N.
Quality Management Coordinator
Blackfeet Service Unit (MT)

Michelle Ruslavage, R.N., B.S.N., C.D.E.
Diabetes Nurse Educator
Claremore Indian Hospital (OK)

Bonnie Smerud, R.N.
Quality Management Coordinator
Red Lake Service Unit (MN)

Sonya Vann, R.N., B.S.N., B.A.
ICU Unit Manager
WW Hastings Hospital (OK)

Mary Wachacha, B.S., CHES
IHS Chief of Health Education
Rockville, MD

TABLE OF CONTENTS

Click one of the links below to jump directly to the related section.

GENERAL INFORMATION

Forward	General Education Topics
Use and Documentation	Use of General Codes
New Codes for 2003	Topics
New Diabetes Curriculum Education	Medical Nutritional Therapy
Type 2 Diabetes Mellitus	Educational Needs Assessment Codes
Gestational Diabetes	Index of Patient Education Protocol Codes

TOP LEVEL PEPC TOPICS

Abdominal Pain	Croup
Administrative Functions	Cystic Fibrosis
Admission to Hospital	Dehydration
Advance Directives	Dental Caries
Allergies	Diabetes Mellitus
Anemia	Dialysis
Anesthesia	Dietary Supplements
Antibiotic Resistance	Discharge from Hospital
Anticoagulation	Diverticulitis/Diverticulosis
Asthma	Domestic Violence
Attention Deficit Hyperactivity Disorder	Dyslipidemias
Autoimmune Disorders	Dysrhythmias
Behavioral and Social Health	Early Childhood Caries
Biological Weapons	Eczema / Atopic Dermatitis
Blood Transfusion	Elder Care
Breast Feeding	End of Life
Cancer	Eye Conditions
Cerebrovascular Disease	Fall Prevention
Chemical Dependency	Family Planning
Chest Pain	Fever
Child Health Newborn (0-60 days)	Frostbite
Child Health Infant (2-12 months)	Gallbladder Disorders
Child Health Toddler (1-3 years)	Gastroenteritis
Child Health Preschool (3-5 years)	Gastroesophageal Reflux Disease
Child Health School Age (5-12 years)	Generalized Anxiety Disorder
Child Health Adolescent (12-18 years)	GI Bleed
Childbirth	Glaucoma
Chronic Kidney Disease	Guillain-Barre Syndrome
Chronic Pain	Hearing Aids
Communicable Diseases	Hearing Loss
Congestive Heart Failure	Heatstroke
Coronary Artery Disease	Hepatitis A,B,C
Crohn's Disease	Human Immunodeficiency Virus

TABLE OF CONTENTS

Hypertension	Peripheral Vascular Disease
Hyperthyroidism	Physical Therapy
Hypothyroidism	Pneumonia
Immunization	Poisoning
Impaired Glucose Tolerance	Postpartum
Impetigo	Postpartum Depression
Influenza	Prenatal
Injuries	Pulmonary Disease
Laboratory	Radiology/Nuclear Medicine
Lead Exposure/ Lead Toxicity	Respiratory Syncytial Virus
Liver	Restraints
Major Depression	Rheumatic Disease
Medical Safety	Seizure Disorder
Medications	Severe Acute Respiratory Syndrome
Menopause	Sexually Transmitted Diseases
Men's Health	Skin and Wound Infections
Metabolic Syndrome	Strep Throat
Neonatal Fever	Sudden Infant Death Syndrome
Neurologic Disorder	Suicidal Behavior
Obesity	Surgical Procedures and Endoscopy
Ocular Diabetes	Tobacco Use
Osteoporosis	Tuberculosis
Otitis Media	Ulcerative Colitis
Pain Management	Upper Respiratory Infection
Pancreatitis	Urinary Tract Infection
Perinatal Loss	Wellness
Periodontal Disease	Women's Health

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:

07/19/97 DM-Diet, poor understanding
10/27/97 DM-Foot care, good understanding
02/07/98 DM-Exercise, good understanding
05/10/98 DM-Diet, fair understanding

A reasonable interpretation of this summary tells you that this patient is trying to understand dietary management of their diabetes but does not yet fully grasp the concepts. It should lead subsequent providers to spend more time reinforcing dietary guidelines.

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 does 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.

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

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, i.e., each educational encounter is to be written on a separate line on the PCC or the patient education is to be written in a “string” on the same line followed by a hyphen (-) or a comma (.). 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.

The educator should document the education using the following steps:

1. Log onto the PCC form using the sign-in box in the upper right-hand corner.
2. Circle “Patient Education” in the section marked “Medications/Treatment/Procedures/Patient Education”
3. Begin your documentation by entering the appropriate:
 - a. ICD-9 code,
 - b. disease state,
 - c. illness or condition for which you are providing the education followed by a hyphen (-) or a comma (,) or in whatever manner your Medical Records or Data Entry staff requests providers to document.
 - i. Examples include writing out in long-hand the disease state, illness or condition - “Tobacco dependence,”
 - ii. Writing out the ICD-9 Code - 250.00 (ICD-9 code for diabetes),
 - iii. Or, writing the “condition” such as head lice.
4. Next, enter the education topic discussed (e.g. complications, nutrition, hygiene) also followed by a hyphen (-) or a comma (,) or in whatever manner your Medical Records or Data Entry staff requests.
5. Determine the patient’s level of understand of the education provided and enter as good- (G), fair (F), or Poor (P) followed by a hyphen (-) or a comma (,) using either the comma or hyphen as directed by your Medical Records or Data Entry staff.
6. If the patient refuses the education encounter, you document this refusal by writing an (R) for refused.
7. 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.
8. Enter the amount of time spent educating the patients. Use specific time amounts rounded off to the minute; 3 minutes, 17 minutes, etc.
9. Initial your entry so that you can get credit for the education provided.

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

10. 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 “plan of action” for themselves to aid in the improvement of their health. This 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	<ul style="list-style-type: none"> • 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

11. It is important to note that if you educate a patient on more than one topic within a category (i.e., Diabetes, Medicines [M] and Diabetes, Lifestyle Adaptation [LA]) these can be separated by a comma or a hyphen (DM-M, LA, Level of Understanding -Time-Your Initials-GS). This is only true if the patient’s level of understanding is the same for all topics. Otherwise separate entries must be made.

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.

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

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 AND COMMUNICATING PATIENT & FAMILY EDUCATION

Implementation date:
Revised:

Review interval: Every year
Responsible person: PFE Committee
Chapter:
Section:

I. Purpose:

To enhance multidisciplinary documentation and communication of patient and family education.

II. Policy:

Multidisciplinary team members provide patient and family education. The teaching process is documented differently in ambulatory and inpatient settings.

Staff members document patient education through the use of “IHS Patient Education Protocols and Codes.”

Staff members document “Education Assessment Codes” on the PCC and PCC+ form. Educational Assessment Codes are used to document patient learning preferences, barriers to learning and readiness to learn.

- Patient Readiness to Learn is assessed and documented for every teaching encounter
- Learning Preferences and Barriers to Learning are reassessed and documented annually.

The RPMS “Health Summary” contains a section in which patient education is summarized. Multidisciplinary team members can determine individual’s previous instruction and learning by reviewing this information.

III. Procedure

Education and assessment information are recorded on documents depending on the care setting:
Inpatient care – the “Multidisciplinary Patient and Family Education Record”

Outpatient care – the “PCC Ambulatory Encounter Record”

Emergency care – the “Emergency Visit Record”

Ambulatory surgery – the “PCC Pre-op Anesthesia Evaluation” form

A. Multidisciplinary Patient and Family Record - Inpatient form:

1. The Inpatient form is part of the patient’s permanent medical record.
2. The form is included in the inpatient admission packet. (The form is initiated in the Emergency Department if the patient is admitted through the ER.)
3. The form is used to document all of the patient education that is provided from admission through discharge.
4. The patient’s name and medical record number are documented on the form in the lower left corner under “addressograph”.
5. The original white copy of the form remains in the inpatient record after discharge.
6. Data entry clerks receive the pink copy of the form. They enter education that is noted on the form.

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

7. The initial In-Patient education assessment is completed within 12 hours of admission.
8. Results of the education assessment (i.e., Readiness to Learn, Learning Preferences, and Barriers to Learning) are documented on the appropriate section of the form.
9. Providers document patient education provided by noting: date and time, ICD-9 Codes, disease state, illness or condition, the Patient Education topic(s), and level of understanding, the time spent in teaching, the patient or person(s) taught and whether a behavior goal was set. Enter the appropriate CPT code if known.
10. The person (s) who receive (s) instruction is/are noted in the column marked “person taught”. If a person other than the patient is taught, their relationship with the patient is written.
11. If additional documentation of a teaching encounter is needed, the small box in the “Patient Education Codes” column is checked. Additional documentation is then written in the Progress Note.
12. Provider signature and core are noted for each entry.

B. PCC Ambulatory Encounter Record; Emergency Visit Record; Pre-Op Anesthesia Evaluation Record:

Providers use either the “PFE box,” or lower portion of the PCC to document readiness to learn, learning preferences, barriers to learning, PFE topic, and level of understanding.

C. General Considerations:

1. Multiple topics may be entered on one line or box only if the patient response is the same. If the patient response varies for different topics taught, only one topic is entered per line, with the appropriate response.
2. Follow-up education is determined based on patient/family’s response to education received.

APPROVAL:

Chair, Patient & Family Education Committee

Date

Nurse Executive

Date

Clinical Director

Date

Professional Service Director

Date

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

Documenting Patient Education and Educational Assessment on the PCC Inpatient Supplement and Discharge Follow-Up Record form (Figure 1):

1. Document the Educational Assessment in the Problem List Additions or Changes field.
2. Document the Patient Education in the Problem List Additions or Changes field underneath the Educational Assessment.
3. It is important to place your provider code and signature on the bottom of the PCC form.

Documenting Patient Education and Educational Assessment on the PCC Ambulatory Encounter Record form (Figure 2):

There are two places on the PCC form where it is appropriate to document patient education.

1. Document the Educational Assessment in the Purpose of Visit field or in the Medications/Treatments/Procedures/Patient Education field toward the bottom of the form.
2. Document the Patient Education in the Purpose of Visit field or in the Medications/Treatments/Procedures/Patient Education field toward the bottom of the form underneath the Educational Assessment.
3. It is also important to place your provider code in the top right hand corner and to sign the bottom of the PCC form.

Documenting Patient Education and Educational Assessment on a PCC+ form (Figure 3 and Figure 4):

1. Document Educational Assessment in the Learning Preferences, Barriers to Learning, and Readiness to Learn fields.
2. Document the Patient Education in the Patient Education table.
3. It is important to place your provider code in the top right-hand corner of the PCC + form, and sign at the bottom right-hand of the PCC+ form.

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

IHS-485 (3/98)

PCC INPATIENT SUPPLEMENT AND DISCHARGE FOLLOW-UP RECORD

1 Document Educational Assessment here

PROBLEM LIST

A-A-C # PROBLEM LIST ADDITIONS OR CHANGES (PRINT ONLY IN THIS SECTION)

**Learning Preferences – TALK
PED – HTN – LA – G – XYZ – 5 min – GS**

REPRODUCTIVE FACTORS G F LC SA TA LMP FP METHOD DATE BEGUN

PROBLEM LIST NOTES
STORE NOTE FOR PROBL. # REMOVE PLAN #

STORE NOTE FOR PROBL. #

A. DISCHARGE ORDER

2 Document the Patient Education here

DATE OF ORDER #

B. DIAGNOSES AND PROBL.

C. OPERATIONS AND / OR PROCEDURES

D. CONDITION AT DISCHARGE

E. MEDICATION, SPECIAL EQUIPMENT, SUPPLIES FOR USE AT HOME

F. FOLLOW-UP RECOMMENDATIONS, SPECIFIC INSTRUCTIONS, DIET, ACTIVITY, WORK TOLERANCE, REFERRALS, RETURN APPOINTMENT

I, _____ (Patient or Representative) agree to follow the above instructions.

ADMISSION DATE

DISCHARGE DATE

PROVIDER SIGNATURE

PROVIDER CODE

Signature

XYZ

Don't know how to document educational assessments?
Please refer to the IHS Patient Education Protocol Manual
#1 Educational Assessment
#2 Patient Education

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

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

IHS-303 (10/98) PL 16-011 N.A.

PCC AMBULATORY ENCOUNTER RECORD

Date _____

Arrival Time _____ AM _____ PM

Clinic _____

Appt. _____

PROBLEM LIST UPDATE
(Enter Problem Numbers From Health Summary)

Remove	Move to Inactive	Move to Active

PROVIDERS

AFFL.	MIL.	INITIALS / CODE
		XYZ

PRIMARY PROVIDER

TEMP _____ PULSE _____ RESP _____

BP _____

WT _____

HT _____

HEAD _____

VISION - UNCORRECTED _____

VISION - CORRECTED _____

INITIALS _____

INITIALS _____

CHIEF COMPLAINT _____

SUBJECTIVE _____

OBJECTIVE _____

Injury? Yes No If yes, Date: _____

CAUSE: _____ Place: _____

(For additional Documentation, see IHS 48-3 Continuation Sheet)

Thromb culture _____

Blood culture _____

OC _____

FAP _____

Health Factors

Tobacco _____

Alcohol _____

Diabetes _____

Heart _____

Chest X-ray _____

OTHER TESTS / PROCEDURES / ORDERS

PROBLEM LIST	A-B-C	#	PURPOSE OF VISIT (PRINT ONLY IN THIS SECTION; DO NOT ABBREVIATE)	Health Factors
			Learning Preference - TALK PED - HTN - LA - G - XYZ - 5 min - GS	

REPRODUCTIVE FACTORS G P LC S LHM

PROBLEM LIST NOTES

STORE NOTE FOR PROB. # _____

STORE NOTE FOR PROB. # _____

MEDICATIONS

DATE BEGUN _____

REMOVE NOTE # _____

MEDICATIONS / TREATMENTS / PROCEDURES / PATIENT EDUCATION

Learning Preference - TALK
PED - HTN - LA - G - XYZ - 5 min - GS

HR # _____

NAME _____

B DATE _____ SEX _____

RESIDENCE _____

FACILITY _____

SSN # _____

TRIBE _____

DATE _____

REVISIT/ REFERRAL TO: _____

PURPOSE: _____

INSTRUCTIONS TO PATIENT: _____

SIGN RELEASE RECORDS

DATE _____

TIME _____

PHYSICIAN SIGNATURE

Signature

1

Document Educational Assessment here

Educational Assessments questions? Please refer to the IHS Patient Education Protocol Manual

2

Document the Patient Education Here

2

Or Document the Patient Education and Assessment

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

DOCUMENTING AND COMMUNICATING PATIENT & FAMILY EDUCATION

«hdr»		«time stamp»			«provider»						
X	Treatment/Procedures	CPT	Supplies	Qty	CPT	X	Injection/Infusion	CPT	X	Immunization	CPT
	«t1»	«1a»	«z1»		«2a»		«s1»	«s1a»		«1»	«1a»
	«t2»	«2a»	«z2»		«2a»		«s2»	«s2a»		«2»	«2a»
	«t3»	«3a»	«z3»		«3a»		«s3»	«s3a»		«3»	«3a»
	«t4»	«4a»	«z4»		«4a»		«s4»	«s4a»		«4»	«4a»
	«t5»	«5a»	«z5»		«5a»		«s5»	«s5a»		«5»	«5a»
	«t6»	«6a»	«z6»		«6a»		«s6»	«s6a»		«6»	«6a»
	«t7»	«7a»	«z7»		«7a»		«s7»	«s7a»		«7»	«7a»
	«t8»	«8a»	«z8»		«8a»		«s8»	«s8a»		«8»	«8a»
	«t9»	«9a»	«z9»		«9a»		«s9»	«s9a»		«9»	«9a»
	«t10»	«10a»	«z10»		«10a»		«s10»	«s10a»		«10»	«10a»
	«t11»	«11a»	«z11»		«11a»		«s11»	«s11a»		Point of Care Lab	CPT
	«t12»	«12a»	«z12»		«12a»		«s12»	«s12a»		Finger Stick Glucose	82348
	«t13»	«13a»	«z13»		«13a»		«s13»	«s13a»		Hemoccult Stool	82270
	«t14»	«14a»	«z14»		«14a»					Hemoglobin	85018
	«t15»	«15a»	«z15»		«15a»					Urine Dip w/o Micro	81000
	«t16»	«16a»									
	«t17»	«17a»									

Purpose of Visit		Prioritize POV = ["1-2-3..."]	Add Active Problems= ["A"]	Inactivate Problem= ["I"]	Remove Problem= ["R"]			
A / I / R	ICD-9	Active Problems & POVs	A / I / R	ICD-9	ICD-9 Pick List	A / I / R	ICD-9	ICD-9 Pick List
	«p1»	«p1»		«d1»	«d1»		«d20»	«d20»
	«p2»	«p2»		«d21»	«d21»		«d21»	«d21»
	«p3»	«p3»		«d22»	«d22»		«d22»	«d22»
	«p4»	«p4»		«d23»	«d23»		«d23»	«d23»
	«p5»	«p5»		«d24»	«d24»		«d24»	«d24»
	«p6»	«p6»		«d25»	«d25»		«d25»	«d25»
	«p7»	«p7»		«d26»	«d26»		«d26»	«d26»
	«p8»	«p8»		«d27»	«d27»		«d27»	«d27»
	«p9»	«p9»		«d28»	«d28»		«d28»	«d28»
	«p10»	«p10»		«d29»	«d29»		«d29»	«d29»
	«p11»	«p11»		«d30»	«d30»		«d30»	«d30»
	«p12»	«p12»		«d31»	«d31»		«d31»	«d31»
	«p13»	«p13»		«d32»	«d32»		«d32»	«d32»
	«p14»	«p14»		«d33»	«d33»		«d33»	«d33»
	«p15»	«p15»		«d34»	«d34»		«d34»	«d34»
	«p16»	«p16»		«d35»	«d35»		«d35»	«d35»
	«p17»	«p17»		«d36»	«d36»		«d36»	«d36»
	«p18»	«p18»		«d37»	«d37»		«d37»	«d37»
	«p19»	«p19»		«d38»	«d38»		«d38»	«d38»

Educational Assessment questions?
Please refer to the IHS Patient
Education Protocol Manual

A / I / R	Additional Purpose of Visit	Plans/Instructions/Appointments/Referrals
	<div style="border: 1px solid black; padding: 10px; display: inline-block;"> <p style="font-size: 24px; margin: 0;">1</p> <p style="text-align: center; margin: 0;">Document Educational Assessment in the Learning Preferences, Barriers to Learning, and Readiness to Learn fields.</p> </div>	
Notes for problem:	Remove Note:	
Notes for problem:	Remove Note:	
Notes for problem:	Remove Note:	
	RTC:	APPT LENGTH:

Patient Education (Circle or Write in Responses for Each Column)						
Learning Preferences	TALK	Barriers to Learning	HEAR	Readiness to Learn	EAGR	
Diagnosis or Code	Topic	Level of Understanding	Provider	Time (min)	Goals	Comments
HTN	LA	<u>G</u> P Group Refused	XYZ	5	G5	Plans to reduce salt intake
		G F P Group Refused				
		G F P Group Refused				
		G F P Group Refused				

X	Preventative Med	New	Estbl	X	E&M Visit Level	New	Estbl
	Infant (< 1 yr.)	99381			Level w/ an "X" and CIRCLE whether NEW or ESTABLISHED patient.		
	Early childhood (1-4 yrs.)	99382			ROS 0, 1 organ sys/ body area	99202	99212
	Late childhood (5-11 yrs.)	99383			ROS 1, 2-7 o.s./b.a.	99203	99213
	Adolescent (12-17 yrs.)	99384			ROS 2-3, 2-7 o.s./b.a.	99204	99214
	18-39 yrs	99385			ROS 10-14, 8-12 o.s./b.a.	99205	99215
	40-64 yrs	99386					99211
	65 yrs & >	99387	99397		Counseling ___ 15 min. / ___ 30 min. / ___ 45 min.		9940

Document the Patient Education in this table.

I HAVE RECEIVED THE ABOVE MEDICATION AND HAVE BEEN OFFERED/RECEIVED COUNSELING	Provider Signature <div style="font-size: 24px; font-weight: bold; text-align: center;">Signature</div>
--	--

«patient» «agesex» «timestamp»
 DOB: «dob» SSN: «ssn» VCN: «uid»
 «b27» #«chart»

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

INPATIENT EDUCATION RECORD

<p>READINESS TO LEARN (RL Code)</p> <p>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</p>	<p style="text-align: center;">PATIENT'S RESPONSE TO EDUCATION (Level of UNDERSTANDING)</p> <p>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</p>												
<p>LEARNING PREFERENCES (LP Code) Assessed Yearly If Assessed Today, Today's Date:</p>	<table style="width: 100%; border: none;"> <tr> <td style="border: none;">Talk (one-on-one)</td> <td style="border: none;">LP-TALK</td> </tr> <tr> <td style="border: none;">Video</td> <td style="border: none;">LP-VIDO</td> </tr> <tr> <td style="border: none;">Group</td> <td style="border: none;">LP-GP</td> </tr> <tr> <td style="border: none;">Read</td> <td style="border: none;">LP-READ</td> </tr> <tr> <td style="border: none;">Do/Practice</td> <td style="border: none;">LP-DOIT</td> </tr> </table>	Talk (one-on-one)	LP-TALK	Video	LP-VIDO	Group	LP-GP	Read	LP-READ	Do/Practice	LP-DOIT		
Talk (one-on-one)	LP-TALK												
Video	LP-VIDO												
Group	LP-GP												
Read	LP-READ												
Do/Practice	LP-DOIT												
<p>BARRIERS TO LEARNING - BAR (Assessed Annually); If Assessed Today, Date Assessed: Check those that apply:</p>													
<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> No Barriers BAR-NONE</td> <td><input type="checkbox"/> Doesn't read English BAR-DNRE</td> <td><input type="checkbox"/> Interpreter Needed BAR - INTN</td> <td><input type="checkbox"/> Social Stressors BAR-STRS</td> <td><input type="checkbox"/> Cognitive Impairment BAR-COGI</td> <td><input type="checkbox"/> Blind BAR-BLND</td> </tr> <tr> <td><input type="checkbox"/> Fine Motor Skills BAR-FIMS</td> <td><input type="checkbox"/> Hard of Hearing BAR-HEAR</td> <td><input type="checkbox"/> Deaf BAR-DEAF</td> <td><input type="checkbox"/> Visually Impaired BAR-VISI</td> <td><input type="checkbox"/> Values/Beliefs BAR-VALU</td> <td><input type="checkbox"/> Emotional Impairment BAR- EMOI</td> </tr> </table> <p>List measures taken to address above barriers:</p> <p>Comments: _____</p>		<input type="checkbox"/> No Barriers BAR-NONE	<input type="checkbox"/> Doesn't read English BAR-DNRE	<input type="checkbox"/> Interpreter Needed BAR - INTN	<input type="checkbox"/> Social Stressors BAR-STRS	<input type="checkbox"/> Cognitive Impairment BAR-COGI	<input type="checkbox"/> Blind BAR-BLND	<input type="checkbox"/> Fine Motor Skills BAR-FIMS	<input type="checkbox"/> Hard of Hearing BAR-HEAR	<input type="checkbox"/> Deaf BAR-DEAF	<input type="checkbox"/> Visually Impaired BAR-VISI	<input type="checkbox"/> Values/Beliefs BAR-VALU	<input type="checkbox"/> Emotional Impairment BAR- EMOI
<input type="checkbox"/> No Barriers BAR-NONE	<input type="checkbox"/> Doesn't read English BAR-DNRE	<input type="checkbox"/> Interpreter Needed BAR - INTN	<input type="checkbox"/> Social Stressors BAR-STRS	<input type="checkbox"/> Cognitive Impairment BAR-COGI	<input type="checkbox"/> Blind BAR-BLND								
<input type="checkbox"/> Fine Motor Skills BAR-FIMS	<input type="checkbox"/> Hard of Hearing BAR-HEAR	<input type="checkbox"/> Deaf BAR-DEAF	<input type="checkbox"/> Visually Impaired BAR-VISI	<input type="checkbox"/> Values/Beliefs BAR-VALU	<input type="checkbox"/> Emotional Impairment BAR- EMOI								

DATE	PATIENT EDUCATION	(Check box to refer to Progress Notes)	PROVIDER INITIALS OR PROVIDER CODE	READINESS TO LEARN CODE (RL)	LEVEL OF UNDERSTANDING CODE	PERSON TAUGHT	TIME	GOAL SET GOAL MET GOAL NOT MET	CPT CODE
	ICD-9 CODE DISEASE STATE, ILLNESS OR CONDITION	EDUCATION TOPIC							
		<input type="checkbox"/>		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		<input type="checkbox"/>		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		<input type="checkbox"/>		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		<input type="checkbox"/>		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		<input type="checkbox"/>		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		<input type="checkbox"/>		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		<input type="checkbox"/>		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		<input type="checkbox"/>		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		<input type="checkbox"/>		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		<input type="checkbox"/>		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		<input type="checkbox"/>		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			

Patient Identification

Providers please sign on back of form

White – Chart Yellow- Billing Pink- Data Entry

PATIENT EDUCATION ASSESSMENT CODES

**Indian Health Service
Patient Education Assessment Codes
For use with the Ambulatory and Emergency PCC
October 2003**

LP	RL	BL	Code:	Response:	Initials:

LP - Learning Preference

1. -Talk
2. -Video
3. -Small Group
4. -Read
5. -Do/Practice

Mnemonics

- LP-TALK
LP-VIDO
LP-GP
LP-READ
LP-DOIT

RL - Readiness to Learn

6. -Eager
7. -Receptive
8. -Unreceptive
9. -Pain
10. -Severity of Illness
11. -Not Ready
12. -Distraction

- RL-EAGR
RL-RCPT
RL-UNRC
RL-PAIN
RL-SVIL
RL-NOTR
RL-DSTR

BAR - Barriers to Learning

13. -No Barriers
14. -Doesn't Read
15. -Interpreter Needed
16. -Cognitive Impairment
17. -Fine Motor Skills Deficit
18. -Hard of Hearing
19. -Deaf
20. -Visually Impaired
21. - Blind
22. - Emotional Impairment
23. -Social Stressors
24. -Values/Belief

- BAR-NONE
BAR-DNRE
BAR-INTN
BAR-COGI
BAR-FIMS
BAR-HEAR
BAR-DEAF
BAR-VISI
BAR-BLND
BAR-EMOI
BAR-STRS
BAR-VALU

NEW CODES FOR 2003

The following codes are new to the Patient Protocol and Coding Manual in the 2003 (9th) edition.

ADV ADVANCE DIRECTIVES

- I - [Information](#)
- L - [Patient Information Literature](#)
- LW - [Living Will](#)
- POA - [Durable Power Of Attorney for Healthcare](#)
- RI - [Patient Rights and Responsibilities](#)

AN ANEMIA

- C - [Complications](#)
- DP - [Disease Process](#)
- FU - [Follow-Up](#)
- L - [Patient Information Literature](#)
- M - [Medications](#)
- N - [Nutrition](#)
- PRO - [Procedures](#)
- TE - [Tests](#)
- TX - [Treatments](#)

ANS ANESTHESIA

- INT - [Intubation](#)

ABX ANTIBIOTIC RESISTANCE

- C - [Complications](#)
- DP - [Disease Process](#)
- FU - [Follow-Up](#)
- L - [Literature](#)
- M - [Medication](#)
- P - [Prevention](#)
- TE - [Testing](#)

BH BEHAVIORAL AND SOCIAL HEALTH

- EX - [Exercise](#)

CHN CHILD HEALTH – NEWBORN (0-60 DAYS)

- SHS - [Second Hand Smoke](#)

CHI CHILD HEALTH- INFANT (2-12 MONTHS)

- SHS - [Second Hand Smoke](#)

CHT CHILD HEALTH – TODDLER (1-3 YEARS)

- SHS - [Second Hand Smoke](#)
- W - [Weaning](#)

CHP CHILD HEALTH - PRESCHOOL (3-5 YEARS)

- SHS - [Second Hand Smoke](#)

CHS CHILD HEALTH – SCHOOL AGE (5-12 YEARS)

- SHS - [Second Hand Smoke](#)
- TO - [Tobacco](#)

CHA CHILD HEALTH- ADOLESCENT (12-18 YEARS)

- CD - [Chemical Dependency](#)
- SHS - [Second Hand Smoke](#)
- TO - [Tobacco](#)

CKD CHRONIC KIDNEY DISEASE

- AP - [Anatomy and Physiology](#)
- C - [Complications](#)
- DP - [Disease Process](#)
- EQ - [Equipment](#)
- LA - [Lifestyle Adaptation](#)
- M - [Medications](#)
- N - [Nutrition](#)
- P - [Prevention](#)
- PRO - [Procedures](#)
- TE - [Tests](#)
- TX - [Treatment](#)

NEW CODES FOR 2003

CF **CYSTIC FIBROSIS**

- C - [Complications](#)
- DP - [Disease Progress](#)
- EQ - [Equipment](#)
- FU - [Follow-Up](#)
- L - [Patient Literature Information](#)
- N - [Nutrition](#)
- SHS - [Secondhand Smoke](#)
- TE - [Tests](#)
- TO - [Tobacco \(Smoking\)](#)
- TX - [Treatment](#)

DEH **DEHYDRATION**

- C - [Complications](#)
- DP - [Disease Process](#)
- FU - [Follow-Up](#)
- L - [Patient Information Literature](#)
- P - [Prevention](#)
- TE - [Tests](#)
- TX - [Treatments](#)

DC **DENTAL CARIES**

- DP - [Disease Process](#)

SUP **DIETARY SUPPLEMENTS**

- C - [Complications](#)
- FU - [Follow-Up](#)
- I - [Supplement Information](#)
- SCH - [Schedule](#)

FALL **FALL PREVENTION**

- C - [Complications](#)
- DP - [Disease Process](#)
- FU - [Follow-Up](#)
- L - [Patient Information Literature](#)
- S - [Safety and Injury Prevention](#)

GAD **GENERALIZED ANXIETY DISORDER**

- C - [Complications](#)
- DP - [Disease Process](#)
- EX - [Exercise](#)
- M - [Medication](#)
- TX - [Treatment](#)

GBS **GUILLAIN-BARRE SYNDROME**

- C - [Complications](#)
- DP - [Disease Process](#)
- FU - [Follow-Up](#)
- L - [Patient Information Literature](#)
- LA - [Lifestyle Adaptation](#)
- M - [Medications](#)
- N - [Nutrition](#)
- TE - [Tests](#)
- TX - [Treatments](#)

FLU **INFLUENZA**

- C - [Complications](#)
- DP - [Disease Process](#)
- FU - [Follow-Up](#)
- IM - [Immunization](#)
- L - [Patient Information Literature](#)
- M - [Medications](#)
- N - [Nutrition](#)
- P - [Prevention](#)

LAB **LABORATORY**

- DRAW - [Phlebotomy](#)
- FU - [Follow-Up](#)
- L - [Literature](#)
- S - [Safety](#)
- TE - [Tests](#)

PB **LEAD EXPOSURE/LEAD TOXICITY**

- C - [Complications](#)
- DP - [Disease Process](#)
- FU - [Follow-Up](#)
- L - [Patient Information Literature](#)
- N - [Nutrition](#)
- P - [Prevention](#)
- SCR - [Screening](#)
- TE - [Tests](#)
- TX - [Treatments](#)

NEW CODES FOR 2003

LIV **LIVER**

- AP - [Anatomy and Physiology](#)
- C - [Complications:](#)
- DP - [Disease Process](#)
- FU - [Follow-Up](#)
- L - [Patient Information Literature](#)
- LA - [Lifestyle Adaptations](#)
- M - [Medications](#)
- N - [Nutrition](#)
- TX - [Treatment](#)

MEDS **MEDICAL SAFETY**

- I - [Information](#)
- TE - [Tests](#)

MPS **MENOPAUSE**

- AP - [Anatomy and Physiology](#)
- C - [Complications](#)
- DP - [Disease Process](#)
- EX - [Exercise](#)
- FU - [Follow-Up](#)
- L - [Literature](#)
- LA - [Lifestyle Adaptations](#)
- M - [Medications](#)
- N - [Nutrition](#)
- PRO - [Procedures](#)
- S - [Safety and Injury Prevention](#)

MSX **METABOLIC SYNDROME**

- C - [Complications](#)
- DP - [Disease Process](#)
- EQ - [Equipment](#)
- EX - [Exercise](#)
- FU - [Follow-Up](#)
- L - [Patient Information Literature](#)
- LA - [Lifestyle Adaptation](#)
- M - [Medications](#)
- N - [Nutrition](#)
- P - [Prevention](#)
- TE - [Tests](#)

PDEP **POSTPARTUM DEPRESSION**

- DP - [Disease Process](#)
- FU - [Follow-Up](#)
- LA - [Lifestyle Adaptations](#)
- L - [Patient Information Literature](#)
- M - [Medications](#)
- N - [Nutrition](#)
- TX - [Treatment](#)

PN **PRENATAL**

- BH - [Behavioral Health](#)
- DC - [Dental Caries](#)
- DV - [Domestic Violence](#)
- GEN - [Genetic Testing](#)
- S - [Safety and Injury Prevention](#)
- SHS - [Second Hand Smoke](#)
- SOC - [Social Health](#)
- STD - [Sexually Transmitted Disease](#)
- TO - [Tobacco](#)

PL **PULMONARY DISEASE**

- VENT [Mechanical Ventilation](#)

XRAY **RADIOLOGY/NUCLEAR MEDICINE**

- C - [Complications](#)
- FU - [Follow-Up](#)
- L - [Literature](#)
- M - [Medications](#)
- PRO - [Procedure](#)
- S - [Safety](#)
- TE - [Tests](#)

SARS **SEVERE ACUTE RESPIRATORY SYNDROME**

- C - [Complications](#)
- DP - [Disease Process](#)
- FU - [Follow-Up](#)
- HM - [Home Management](#)
- HY - [Hygiene](#)
- L - [Patient Information Literature](#)
- LA - [Lifestyle Adaptation](#)
- M - [Medications](#)
- P - [Prevention](#)
- TE - [Testing](#)
- TX - [Treatment](#)

NEW CODES FOR 2003

SIDS **SUDDEN INFANT DEATH
SYNDROME**

- I - [Information](#)
- L - [Patient Information Literature](#)
- P - [Prevention](#)
- S - [Safety and Injury Prevention](#)
- SHS - [Second-Hand Smoke](#)

SPE **SURGICAL PROCEDURES AND
ENDOSCOPY**

- PRO - [Procedures](#)

UTI **URINARY TRACT INFECTION**

- AP - [Anatomy and Physiology](#)
- HY - [Hygiene](#)

ABD-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications of abdominal pain and verbalize 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 viscus, 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 adherence to the medication regimen.
3. Encourage the patient to carry a list of current medications.

ABD-N NUTRITION

OUTCOME: The patient/family will have an understanding of 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 have an understanding of 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-TE TESTS

OUTCOME: The patient/family will have an understanding of 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, etc.

ABD-TX TREATMENT

OUTCOME: The patient/family will have an understanding of 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.

AF-B BENEFITS OF UPDATING CHARTS

OUTCOME: The patient will be able to identify some benefits to themselves and to the clinic/hospital as the result of keeping charts updated.

STANDARDS:

1. Identify benefits to the patient, i.e., insurance deductible without a co-payment, increased services at this facility, ability of the physician or other provider to contact the patient in case of emergency or lab results which need immediate attention.
2. Identify benefits to the hospital/clinic, i.e., increase of services through third party collections.
3. Refer the patient to benefits coordinator or other resources as appropriate.

AF-FU FOLLOW-UP

OUTCOME: The patient will keep the business office updated at least once per year.

STANDARDS:

1. Discuss the importance of maintaining updated information.
 - a. Address
 - b. Telephone number
 - c. Emergency contact
 - d. Third party payers if any
 - e. Name changes
2. Discuss the procedure for providing updated and current information as soon as it becomes available.
3. Updated information will improve the delivery of care and treatment at the IHS Clinic/Hospital. No discrimination will occur based on availability of third party payment resources.

AF-REF REFERRAL PROCESS

OUTCOME: The patient/family will understand the referral process and financial responsibilities. (Choose from the following standards as appropriate.)

STANDARDS:

1. Emphasize that referrals to outside providers by Indian Health Service primary providers typically will be processed by Contract Health Services.
2. Explain the procedure for the referral to the private sector is usually based on a priority system and/or waiting list.
3. Explain that coverage by insurance companies and Medicare/Medicaid packages will be utilized prior to contract health service funds in most cases. The Indian Health Service is a payer of last resort.
4. Discuss the rules/regulations of Contract Health Services.
5. Refer as appropriate to community resources for Medicaid/Medicare enrollment, i.e., benefits coordinator.
6. Discuss the importance of follow-up care and the requirement to notify contract health services of any future appointments and procedures by the private sector. Referrals are for one visit only. Future and/or additional referrals must be approved prior to the appointment.

ADM-EQ EQUIPMENT

OUTCOME: The patient/family will verbalize understanding and demonstrate (when appropriate) proper use of hospital equipment.

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, 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.

ADM-OR ORIENTATION

OUTCOME: The patient/family will have a basic understanding of the unit policies, the immediate environment, and the equipment utilized in patient care, including IVs or other venous or arterial lines.

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. Identify any equipment (IVs, monitors etc.) utilized for patient care and explain their basic functions and or purposes as appropriate.
6. Explain the reason for and use of bed side rails in the hospital setting. Discuss the hospital policy regarding side rails as appropriate.
7. Explain the unit visiting policies, including any restrictions to visitation.
8. Explain the hospital smoking policy.
9. Discuss the hospital policy regarding home medications/supplements brought to the hospital.

ADM-POC PLAN OF CARE

OUTCOME: The patient/family will have a basic understanding of the plan of care, including the plan for pain management and anticipated results of the plan and discharge planning.

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 (medication, physical therapy, dressing changes, etc.)
 - e. Advance directives
 - 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 have an understanding of 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.

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.

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, nutritionist 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 medication adherence.

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 have an understanding of the test(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.

AN-C COMPLICATIONS

OUTCOME: The patient/family will have an understanding of the complications of untreated anemia.

STANDARDS:

1. Explain that failure to adhere to 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 have an understanding of 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 adherence 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 have an understanding of the importance of their prescribed medications and adherence to 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 have an understanding of 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 have an understanding of 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 have an understanding of 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.

ANS - C COMPLICATIONS

OUTCOME: The patient/family will understand common and important complications of anesthesia and symptoms that should be reported.

STANDARDS:

1. Discuss the common and important complications of anesthesia, i.e., potential for death, disability, drug reaction, pain, nausea and vomiting, disorientation, as appropriate.
2. Advise the patient/family to report any unexpected symptoms, i.e., shortness of breath, dizziness, nausea, chest pain, numbness.

ANS-EQ EQUIPMENT

OUTCOME: The patient/family will verbalize understanding and demonstrate when appropriate, the use of equipment to be used post-operatively. The patient/family will further understand as appropriate, equipment to be used during anesthesia.

STANDARDS:

1. Discuss the equipment to be used during anesthesia, including monitoring and treatment devices.
2. Discuss the function and use of any equipment that will be used postoperatively for monitoring or continued analgesia, i.e., cardiac and apnea monitors, pulse oximeter, and PCA pumps as appropriate.

ANS - FU FOLLOW-UP

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

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 indications for returning to see the provider prior to the scheduled appointment.

ANS-INT INTUBATION

OUTCOME: The patient/family will verbalize 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.

ANS - L LITERATURE

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

STANDARDS:

1. Provide the patient/family with written information about anesthesia or anesthetics.
2. Discuss the content of the patient literature with the patient/family.

ANS-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of 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.

ANS - PO POSTOPERATIVE

OUTCOME: The patient/family will understand some post-anesthesia sequelae.

STANDARDS:

1. Review expected post-operative course with the patient/family.
2. Discuss with the patient/family common or important post-anesthetic side effects.
3. Explain some causes of post-anesthetic side effects and what courses of action might be required.

ANS-PR PREOPERATIVE

OUTCOME: The patient and family will be prepared for the specific type of anesthetic to be used during a procedure or surgery.

STANDARDS:

1. Explain pre-anesthetic preparation, including NPO (nothing by mouth) requirements and the medication(s) to take prior to the procedure.
2. Explain the type of anesthetic that is medically suggested. Discuss risks and benefits to the patient and unborn infant if applicable.
3. Explain alternative type(s) of anesthetic as appropriate.
4. Discuss common and important complications of anesthesia.
5. Discuss the role of the anesthetic care provider during a surgical/procedure case.
6. Explain the effects of anesthesia on the patient after the procedure is completed.

ABX-C COMPLICATIONS

OUTCOME: The patient/family will understand that antibiotics are reserved for bacterial infections and may have deleterious effects if used when treating viral infections

STANDARDS:

1. Discuss the term antibiotic resistance as bacteria developing methods to survive exposure to antibiotics.
2. Explain why antibiotics are only effective in treating bacterial infections.
3. Discuss the potential to create resistant bacteria every time an antibiotic is used.
4. Discuss the following ways to minimize antibiotic resistance:
 - a. Restrict antibiotic use to bacterial infections and not for viral infections
 - b. Educate patients why “saving” or “sharing” antibiotics can cause resistance
 - i. Medications may be expired and have questionable efficacy
 - ii. Antibiotics for one type of infection may not treat another type of infection due to resistance
 - iii. When medications are saved or shared, the original infection needing antibiotic did not receive a full course and may reoccur resistant to the antibiotic.
5. Instruct on the importance of taking the medication as prescribed regarding dose and duration.
6. Advise patients to take their antibiotics for the full course of therapy as prescribed even if they “feel better” after a few days. The duration of therapy can keep infections from coming back and keep bacteria from developing resistance.
7. Discuss the implications of taking an antibiotic that is not needed:
 - a. Creating antibiotic resistance bacteria
 - b. Side effects usually nausea, vomiting, and diarrhea
 - c. Allergic reactions
 - d. Secondary infections, i.e., yeast infections, diarrhea
 - e. Cost
8. Discuss the impact of resistant bacteria on the course of therapy and the limitations it provides in treatment.
 - a. Resistance limits treatment options to antibiotics that may be more expensive, have more side effects, or require hospitalization for administration

- b. There is a risk of developing bacteria in your body that are completely resistant to all known antibiotics and may be fatal.

ABX-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the disease process of antibiotic resistance.

STANDARDS:

1. Discuss that antibiotic resistance occurs when bacteria change their structure and/or DNA so antibiotics no longer work. The bacteria have developed ways to survive antibiotics that are meant to kill them.
2. Discuss how antibiotic resistance may develop:
 - a. Antibiotic resistance can occur by the bacteria developing a way to block the antibiotic, deactivate the antibiotic, or pump the antibiotic out of the bacteria.
 - b. Antibiotic resistance occurs from exposure to an antibiotic when:
 - i. Antibiotics are given to patients more often than guidelines set by federal and other healthcare organizations recommend. For example, patients sometimes ask their doctors for antibiotics for a cold, cough, or the flu, all of which are viral and don't respond to antibiotics.
 - ii. Patients who are prescribed antibiotics who don't take the full dosing regimen can contribute to resistance. The bacteria is exposed to sub-therapeutic concentrations of antibiotic or duration of therapy allowing for the bacteria to survive and resistance to occur.
 - iii. Food-producing animals are given antibiotic drugs for therapeutic reasons, disease prevention or production reasons. These drugs have the downside of potentially causing microbes to become resistant to drugs used to treat human illness.
3. Discuss which illnesses are commonly caused by viruses and do not require antibiotics. Some examples include colds, flu, coughs, bronchitis, ear infections, sinus congestion, and sore throats. Viral infections usually cannot be specifically treated with medications and must resolve on their own. Often the symptoms of viral infections can be helped with prescription or over-the-counter medications.
4. Discuss which illnesses are commonly caused by bacteria and require antibiotics including Streptococcal pharyngitis, pneumonia, ear, sinus, and urinary tract infections.
5. Explain how antibiotics specifically target bacteria and do not have any effect on the treatment of viruses.

ABX-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up if symptoms do not resolve after antibiotic treatment or viral infections.

STANDARDS:

1. Encourage the patient to seek follow-up management for viral infections if symptoms significantly worsen, last longer than 10 days, or fever lasts longer than 72 hours.
2. Encourage the patient to seek follow-up management for bacterial infections if the patient has taken the full course of antibiotics and symptoms return, symptoms worsen while taking antibiotics, or symptoms do not improve after a certain time period determined appropriate by the provider.

ABX-L LITERATURE

OUTCOME: The patient/family will receive written information about antibiotic resistance, viral illnesses, or bacterial infections.

STANDARDS:

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

ABX-M MEDICATION

OUTCOME: The patient/family will understand the role of appropriate antibiotic choice to minimize antibiotic resistance and to treat antibiotic resistant bacteria.

STANDARDS:

1. Discuss with the patient/family appropriate empiric therapy for the bacterial infection that is suspected.
2. Discuss the potential need to change the antibiotic after sensitivity testing due to antibiotic resistance of the infection.
3. Discuss the need to follow the directions for duration of therapy and doses per day exactly to prevent the development of antibiotic resistance and to prevent reoccurrence of the infection or development of superinfection.

ABX-P PREVENTION

OUTCOME: The patient/family will understand actions that may be taken to prevent the development of antibiotic resistant bacteria.

STANDARDS:

1. Instruct the patient/family to complete the full course of antibiotics at the proper dosing and duration.
2. Advise patient not to share or save antibiotics for the use by others or for future use.
3. Discuss with patient the importance of evaluating whether an infection is viral or bacterial. Encourage the patient not to insist on antibiotics if the infection is viral.

ABX-TE TESTING

OUTCOME: The patient/family will understand the importance of culturing a bacterial infection when possible and determining an appropriate antibiotic.

STANDARDS:

1. Discuss with the patient/family when it is appropriate to do cultures and antibiotic resistance testing.
2. Explain what test(s) will be ordered. Provide information on the necessity, benefits, and risks of the tests.
3. Explain how test results will be used to guide therapy.
4. Emphasize that there are still some infections for which empiric therapy is appropriate (i.e., sinus infections, community acquired pneumonia, strep throat) and sensitivity testing may not be required.
5. Explain that serious infections like hospital acquired pneumonia and recurrent infections may require culture and antibiotic sensitivity testing to select the appropriate treatment.
6. When appropriate, discuss that not all types of bacteria may be cultured and that additional antibiotics may have to be used to treat anaerobic bacteria.

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 have an understanding of 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 treatment plan adherence 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 (bleeding, stroke, adverse drug reactions, etc.).
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-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 comply with treatment regimens (medications, peak flows, etc.) or from exposure to environmental triggers or infections.
2. Emphasize early medical intervention for minor URI's, 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 adherence to the treatment plan. Explain that failure to comply 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 (smoke, animal dander, cold air, exercise, etc.)
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 patient's exercise recommendations or restrictions as appropriate to this patient's disease condition.

STANDARDS:

1. Review the type(s) of exercise recommended for this patient.
2. Discuss the importance of consulting the primary provider before beginning any exercise program.
3. 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 treatment plan adherence. 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 (cigarette smoke, stress, environmental smoke, pollen, mold, dust, roaches, insecticides, paint fumes, perfumes, animal dander, cold air, sulfites, aspirin, etc.) 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 adherence, 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 (cigarette smoke, stress, environmental smoke, pollen, mold, dust, roaches, insecticides, paint fumes, perfumes, animal dander, cold air, sulfites, aspirin, etc.) 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 adherence 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 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-TO TOBACCO (SMOKING)

OUTCOME: The patient and/or family will have an understanding of 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](#).**

ADD-DP DISEASE PROCESS

OUTCOME: The patient and family will understand the nature of the disorder that is categorized into two diagnostic criteria: inattention and/or hyperactivity-impulsivity. The disorder usually manifests itself in childhood and continues into adulthood.

STANDARDS:

1. Discuss the current theories of the causes of attention deficit disorder:
 - a. Neurological: Brain damage
 - b. Neurotransmitter Imbalances: Dopamine, Norepinephrine, Serotonin - likely but not proven
 - c. Environmental toxins: lead, prenatal exposure to cigarette smoke and alcohol
 - d. Dietary Substances: Food additives, sugar, milk - not supported by most research
 - e. Genetics
 - f. Environmental Factors: Parenting and social variables
2. Discuss the three types of attention deficit disorder: Predominately Inattentive, Predominately Hyperactive/Impulsive or a combination of both.
3. Discuss the problems associated with attention deficit disorder: academic achievement, learning disabilities, health problems, social problems, and, sleep problems.
4. Discuss the prognosis for attention deficit disorder.

ADD-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. Discuss prescription medications and how follow-up relates to the ability of the patient to get refills of medications.

PATIENT EDUCATION PROTOCOLS: ATTENTION DEFICIT HYPERACTIVITY DISORDER

ADD-GD GROWTH AND DEVELOPMENT

OUTCOME: The patient/family will understand that the growth of children with ADD/ADHD needs to be monitored closely.

STANDARDS:

1. Refer to [ADD-N](#).

ADD-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

ADD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family have an increased understanding of the factors that contribute to better outcomes for ADD Children and Adults.

STANDARDS:

1. Explain that the treatment of ADD requires family involvement in an ongoing fashion.
2. Discuss that effective therapy often requires restructuring home, community and school environments.
3. Explain that use of multiple, consistent, persistent interventions are necessary for a good outcome.
4. Discuss the need to advocate for, not against the child.
5. Discuss the importance of positive reinforcement for good behaviors and support of self esteem.
6. Discuss the effects of parental stress and marital problems on children. Further discuss that ADD may exacerbate parental stress and marital problems. Explain that these problems should not be ignored and that appropriate help should be sought as soon as the problem is identified.

PATIENT EDUCATION PROTOCOLS: ATTENTION DEFICIT HYPERACTIVITY DISORDER

ADD-M MEDICATION

OUTCOME: If applicable, the patient and family will understand the importance of complying with a prescribed medication regimen.

STANDARDS:

1. Review the proper use, benefits and common side effects of the prescribed medication.
2. Discuss drug and food interactions with prescribed medication.
3. Briefly review the mechanism of action of the medication if appropriate.
4. Explain that the medication should be stored in a safe place to avoid accidental overdoseage.

ADD-N NUTRITION

OUTCOME: The patient/family will understand nutritional requirements for the child with ADD/ADHD and will plan for adequate nutritional support.

STANDARDS:

1. Explain that the hyperactive child will often burn more calories than age-matched peers and will require additional caloric intake for adequate growth.
2. Discuss that many medications used for ADD/ADHD suppress appetite. Timing of medication may need to be adjusted to optimize hunger at mealtimes.
3. Explain that children with ADD are distractible and may need to be reminded to eat.

ADD-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed to diagnose ADD/ADHD.

STANDARDS:

1. Discuss the test(s) to be performed to diagnose ADD/ADHD. Answer the patient/family questions regarding the testing process.
2. Refer to Behavioral Health or other community resources as appropriate.

PATIENT EDUCATION PROTOCOLS: ATTENTION DEFICIT HYPERACTIVITY DISORDER

ADD-TX TREATMENT

OUTCOME: The patient and family will understand that the four components of treatment of ADD symptoms are based on biologically-based handicaps.

STANDARDS:

1. Discuss that the therapy for ADD is multifactorial and may consist of:
 - a. Parent Education
 - b. Behavior Management and Behavior Therapy
 - c. Educational Management
 - d. Medication Therapy

ATO-C COMPLICATIONS

OUTCOME: The patient/family will understand how to lessen the complications of their particular immune disorder.

STANDARDS:

1. Review the common complications associated with the patient's disease.
2. Review the treatment plan with the patient/family. Explain that complications are worsened by non-adherence with the treatment plan.

ATO-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the patient's particular Autoimmune Disease process.

STANDARDS:

1. Discuss the pathophysiology of the patient's autoimmune disorder and how it may affect function and lifestyle.
2. Explain that treatments are highly individualized and may vary over the course of the disease.
3. Explain that outcome varies with the specific disorder. Most are chronic, but many can be controlled with treatment.
4. Explain that symptoms of autoimmune disease vary widely depending on the type of disease. A group of very non-specific symptoms often accompany autoimmune disease. Review these symptoms with the patient.
 - a. Tires easily
 - b. Fatigue
 - c. Dizziness
 - d. Malaise
 - e. Fever, very low grade temperature elevations
5. Explain that specific autoimmune disease results in either destruction of an organ or tissue or increase in size of an organ or tissue.

ATO-FU FOLLOW-UP

OUTCOME: The patient/family will understand 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, social services, mental health services, nutritionist, and community health services as appropriate.
2. Assess the need for any additional follow-up and make the necessary referrals.

ATO-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the patient's autoimmune disorder.

STANDARDS:

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

ATO-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand what lifestyle adaptations are necessary to cope with the patient's specific autoimmune disorder.

STANDARDS:

1. Assess the patient's and family's level of acceptance of the disorder.
2. Refer to Social Services, Mental Health and community services as appropriate.
3. Review the lifestyle areas that may require adaptations: diet, physical activity, sexual activity, role changes, communication skills and interpersonal relationships.

ATO-M MEDICATIONS

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

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 medication as prescribed.

ATO-N NUTRITION

OUTCOME: The patient/family/caregiver will understand the role of appropriate nutrition in the management of the patient's autoimmune disease.

STANDARDS:

1. Explain that many patients with autoimmune diseases will have altered nutritional requirements. Refer to dietitian as indicated.
2. Explain that some autoimmune diseases may become better or worse with changes in diet.
3. Review the patient's current nutritional habits. Encourage the patient/family/caregiver to keep a food diary for review.
4. Emphasize the importance of adherence to the prescribed nutritional plan.

ATO-TE TESTING

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

STANDARDS:

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

ATO-TX TREATMENT

OUTCOME: The patient/family/caregiver will understand the possible treatments which will be available based upon 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. Emphasize the importance of adhering to the treatment plan, including scheduled follow-up.
3. Refer to community resources as appropriate.

BH-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the process of a psychological diagnosis or issue and develop a plan for appropriate activities of daily living.

STANDARDS:

1. Explain the mental health condition and causes. Reassure the patient.
2. Explain how the diagnosis is made (by symptoms, through testing, etc. as applicable).
3. Discuss options for treatment, both short-term and long-term.

BH-EX EXERCISE

OUTCOME: The patient will understand the importance of exercise as a part of treatment plan.

STANDARDS:

1. Explain that moderate exercise may increase energy, improve circulation, enhance sleep, and reduce stress and depression.
2. Encourage a program of regular exercise for optimal benefit.

BH-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.

BH-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the behavioral health.

STANDARDS:

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

BH-M MEDICATIONS

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

STANDARDS:

1. Review proper use, benefits, common side effects, and length of therapy for the prescribed medications.
2. Emphasize adherence and continuation of therapy as prescribed even if improvement is not seen immediately. Emphasize how important it is to have medications, including injectable medications, administered at the correct time.
3. Emphasize the importance of communication with the physician and pharmacist about other medications currently being taken and any new medications prescribed while taking this medicine.
4. Emphasize that many traditional medicines, herbal remedies, and over-the-counter medicines can have dangerous interactions with psychiatric drugs. Reinforce the importance of talking to the physician and/or pharmacist before taking any non-prescription or prescription treatment while on this medicine.
5. Inform the patient that if their medication is changed, there may be a few days to a few weeks waiting period before a new medication is started.
6. Inform the patient that alcohol is contraindicated while taking this medication and that use of recreational drugs may make the medication ineffective.

BH-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.

BH-WL WELLNESS

OUTCOME: The patient/family will understand some of the factors that 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 behavioral 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 drugs of abuse can be extremely harmful to behavioral and emotional health. **Refer to [CD](#).**
5. Emphasize that behavioral and emotional problems often co-exist with domestic violence. Encourage the patient to use local resources as appropriate.
6. **Refer to [DV](#).**

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 adherence to the treatment regimen.
3. Discuss common or significant complications which may result from treatment(s).

BWP-DP DISEASE PROCESS

OUTCOME: The patient/family will have an understanding of 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 Woollsorters' 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 osteomyelitis, 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 HF, and yellow fever. Kyasanur 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 CO₂ 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 mucociliary 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 botulism^{3/4}food 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 and dose 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 adherence to 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 comply 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 adherence to 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-TE TESTING

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 have an understanding of 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-C COMPLICATIONS

OUTCOME: The patient/family will have an understanding of 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-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 have an understanding of 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-TX TREATMENT

OUTCOME: The patient/family will have an understanding of 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.

BF-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The parent and/or family will have an understanding of the anatomy and physiology of breastfeeding.

STANDARDS:

1. Explain external anatomy of the breast, i.e., areola, nipple.
2. Explain internal anatomy of the breast, i.e., ducts, glands.
3. Explain the physiology of breastfeeding, i.e., colostrum, milk becoming abundant (let down) by day 2-3, milk ejection reflex, importance of a relaxed mother.

BF-BB BENEFITS OF BREASTFEEDING

OUTCOME: The parent(s) will be able to identify several benefits of breastfeeding.

STANDARDS:

1. Identify benefits to the mother, i.e., improved bonding, skin to skin contact, convenience, cost, improved postpartum weight loss.
2. Identify benefits to the baby, i.e., improved bonding, immunity to illnesses, natural nutrition, easier to digest.

BF-BC BREAST CARE

OUTCOME: The parent and/or family will be able to identify methods to use for management of engorgement and tenderness.

STANDARDS:

1. Explain techniques for management of engorgement and tenderness, i.e., ice packs, cool moist tea bags, minimal pumping, lanolin, cool showers, supportive nursing bra.
2. Explain signs of infection (mastitis), i.e., cold-like symptoms, fever, redness and soreness of the breast.
3. Explain signs and symptoms of infection (candida), i.e., soreness, cracking, bleeding, redness.
4. Explain the importance of seeking medical care for infections.

BF-BP BREASTFEEDING POSITIONS

OUTCOME: The parent and/or family will understand all 4 breastfeeding positions and provide a demonstration as appropriate.

STANDARDS:

1. Demonstrate the four breastfeeding positions: cradle position, modified cradle position, football position, side-lying position.
2. Emphasize the importance of burping before latching baby on to other breast and at the end of each feeding.

BF-CS COLLECTION AND STORAGE OF BREAST-MILK

OUTCOME: The parent and/or family will gain an understanding of the different pumps available in addition to hand expressing. The parent and/or family will also understand safety rules for storing breast milk.

STANDARDS:

1. Explain the use of manual and electric breast pumps as well as hand expressing.
2. Discuss storage safety rules, i.e., milk stays good in the refrigerator for 24 hours, refrigerator freezer for 1 month and deep freezer for 3 months.

BF-EQ EQUIPMENT

OUTCOME: The patient/family will verbalize understanding and demonstrate (when appropriate) proper use and care of equipment used for breast-feeding.

STANDARDS:

1. Discuss equipment to be used during breast-feeding. **Refer to [BF-CS](#).**
2. Discuss and/or demonstrate proper use and care of equipment; participate in return demonstration by the new mom.
3. Emphasize proper cleaning of equipment.

BF-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.

BF-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent and/or family will have an understanding of the various growth and developmental stages of a nursing baby.

STANDARDS:

1. Explain growth and development stages in reference to a nursing baby, i.e., bonding, making eye contact with the baby while nursing, baby showing interest in surrounding while nursing, baby gaining independence via crawling/walking, periods of frequent nursing due to growth spurts, periods of baby showing no interest in nursing.

BF-HC HUNGER CUES

OUTCOMES: The parent and/or family will be able to name three early and three late hunger cues.

STANDARDS:

1. Explain early hunger cues, i.e., low intensity cry, small body movements, smacking, rooting.
2. Explain late hunger cues, i.e., high intensity cry, large body movements, arched back.

BF-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

BF-LA LIFESTYLE ADAPTATIONS

OUTCOME: The parent and/or family will understand life style adaptations necessary for breastfeeding.

STANDARDS:

1. Discuss methods for breastfeeding discreetly in public.
2. Discuss the importance of stress management and relaxation as it relates to milk production and let-down.
3. Identify community resources available for breastfeeding support, i.e., La Leche League, WIC, community health nursing, breastfeeding educators, etc.
4. Explain the importance of eliminating the baby's exposure to nicotine. Recommend complete abstinence from nicotine; if abstinence is not possible, do not smoke or use tobacco products at least one hour prior to breastfeeding.
5. Discuss the possibility of and methods for continuing breastfeeding after returning to work.

BF-M MATERNAL MEDICATIONS

OUTCOME: The parent/family will understand that most medications are safe during breastfeeding but that some medications are detrimental to breastfed infants.

STANDARDS:

1. Explain that most medications are safe in breastfeeding.
2. Explain that there are a few medications that are absolutely contraindicated in breastfeeding such as all street drugs, most anticonvulsants, some antidepressants, chemotherapeutic agents, radio-pharmaceuticals, etc. (Note: this information is subject to change and current resources should be consulted before counseling a patient about any medication.)
3. Emphasize to the parent/family that before the breastfeeding mother starts any new medication, over-the-counter medicine, dietary supplement, herbal or traditional remedy, she should consult her physician or other health care provider knowledgeable about medications in breastfeeding.

BF-MK MILK INTAKE

OUTCOME: The parent and/or family will have an understanding of optimal frequency of feedings as well as adequate quantity of infant's stools and wet diapers.

STANDARDS:

1. Discuss audible swallowing as a mechanism for assessing milk intake.
2. Explain frequency of feedings, i.e., 15-20 minutes each breast, feedings every 2-3 hours, 7-8 feedings each 24 hour period.
3. Explain normal infant output, i.e., 1-5 days old - 2 or more stools each 24 hour period, 5-7 wet diapers; after 4-5 days old - 4-5 stools each 24 hour period, 7-10 wet diaper; 1-2 months old less frequent stooling.

BF-N NUTRITION (MATERNAL)

OUTCOME: The parent/family will understand the nutritional needs of breastfeeding mothers.

1. Stress the importance of a balanced diet (may normalize weight but don't go on a diet).
2. Identify foods to avoid if necessary, i.e., chocolate, gas forming foods and highly seasoned foods.
3. Emphasize the increased need for water in the diet of breastfeeding mothers.

BF-ON LATCH-ON

OUTCOME: The parent and/or family will have and understanding of how to achieve an effective latch-on. Demonstration of effective latch-on will be given as appropriate to the situation.

STANDARDS:

1. Identify infant readiness cues, i.e., infant alert, wide open mouth.
2. Explain mother readiness, i.e., C-hold, position.
3. Explain methods of determining good latch-on.

BF-T TEETHING

OUTCOME: The parent/family will have an understanding of teething behaviors. The parent/family will identify ways to prevent biting while nursing, in addition, the parent/family will understand how to discourage persistent biting.

STANDARDS:

1. Explain the normal stages of teething, i.e., sore swollen gums and the baby's tendency to nurse to ease discomfort.
2. Identify ways to anticipate and prevent biting, i.e., giving the baby your complete attention while nursing, learn to recognize the end of a nursing, don't force a nursing, keep milk supply plentiful, keep breastfeeding relaxed and pleasant.
3. Explain techniques to use for discouraging persistent biting, i.e., stop the feeding, offer an acceptable teething object, quickly put baby on the floor, keep finger poised near baby's mouth to break the suction if needed, offer positive reinforcement when baby doesn't bite.

BF-W WEANING

OUTCOME: The parent/family will have an understanding of methods to effectively wean the child from breastfeeding.

STANDARDS:

1. Discuss appropriate reasons for weaning the infant from breastfeeding.
2. Explain readiness signs of weaning that the infant may display.
3. Explain the process of weaning, i.e., replace one feeding at a time with solids, bottle or cup.
4. Explain social ways to replace breastfeeding, i.e., reading books together, playing with toys, cuddling together.
5. Refer to community resources as appropriate.

CA-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient and family will have a basic understanding of the normal function of organ(s)/site being affected by the cancer.

STANDARD:

1. Explain relationship of anatomy and physiology of the system involved and how it may be affected by this tumor.
2. Discuss changes in health of the patient as it relates to the cancer site and the potential impact on health and well being.

CA-C COMPLICATIONS

OUTCOME: The patient/family/caregiver will understand that both the disease process and the therapy may have complications which may or may not be treatable.

STANDARDS:

1. Explain that cancer, depending on the primary site, size of the tumor, or degree of metastasis, and specific treatment regimens have various and diverse complications.
2. Explain that many therapies for cancer depress the immune system and that infection is a major risk.
3. Discuss that many therapies for cancer will have as a side-effect nausea and vomiting. This can often be successfully medically managed.
4. Discuss that pain may be a complication of the disease process or the therapy.
Refer to [PM](#).

CA-DP DISEASE PROCESS

OUTCOME: The patient/family/caregiver will have an understanding of the definition of cancer, and types affecting American Indian population and treatment options available to alleviate specific to the patient's diagnosis.

STANDARD:

1. State the definition of Cancer, the specific type, causative and risk factors and effect of primary site of the cancer and staging of the tumor.
2. Discuss signs and symptoms and usual progression of specific cancer diagnosis.
3. Discuss significant complications of treatment.
4. Explain that many cancers are curable and most are treatable. Discuss prognosis of specific cancer.
5. Discuss the importance of maintaining a positive mental attitude.

CA-EQ EQUIPMENT

OUTCOME: The patient and family will verbalize understanding of durable medical equipment and demonstrate proper use and care of equipment.

STANDARDS:

1. Discuss the indication for and benefits of prescribed home medical equipment.
2. Demonstrate the proper use and care of medical equipment.
3. Review proper function and demonstrate safe use of equipment.
4. Discuss infection control principles as appropriate.

CA-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand the importance of adherence to treatment regimen and to maintain activities to follow up with outside referral sources.

STANDARDS:

1. Emphasize 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 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.

CA-HM HOME MANAGEMENT

OUTCOME: The patient and family will understand home management of cancer process and develop a plan for implementation. The patient/family/caregiver will understand the coordination of 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 on a day to day or week to week basis.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources as appropriate. Refer to hospice care as appropriate.
4. Refer to support groups as appropriate.

CA-L LITERATURE

OUTCOME: The patient/family/caregiver will receive written information of cancer and organizations that assist in the care of patients with cancer such as the American Cancer Society.

STANDARDS:

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

CA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient and family will attempt to make necessary lifestyle adaptations to prevent or delay the onset of complications or to improve overall quality of life.

STANDARDS:

1. Review lifestyle behaviors the patient has control over such as diet, exercise, and habits related to risk of disease.
2. Encourage adherence with treatment plan.
3. Emphasize importance of the patient adapting to a lower risk, healthier lifestyle.
4. Review community resources available to assist the patient making changes. Refer as appropriate.

CA-M MEDICATIONS

OUTCOME: The patient and family will understand choice of medication to be used in management of cancer disease.

STANDARDS:

1. Explain medication regimen to be implemented. **Refer to [PM](#).**
2. Explain medication to be used including dose, timing, adverse side effects including drug-food interactions.
3. Explain affects of chemotherapy such as hair loss, nausea, vomiting and altered immune status.
4. Caution on the administration of live vaccines to self and family as appropriate. Discuss the implications of immunization advantages and disadvantages.

CA-N NUTRITION

OUTCOME: The patient, family/caregiver will receive nutritional assessment and counseling. Patient will verbalize understanding of need for a well balanced nutritional plan.

STANDARDS:

1. Assess patient's current nutritional level and determine an appropriate meal plan.
2. Discuss ways the meal plan can be enhanced to decrease nausea and vomiting, or other complications associated with the therapy or the disease process.
3. Explain that medications may be provided to enhance appetite, decrease adverse effects of therapy or the disease process to assist in maintenance of proper nutrition.
4. Review normal nutrition needs for optimum health.
5. Discuss current nutritional habits and assist in developing a plan to implement the prescribed nutritional plan.
6. Discuss the patient's right to decline nutritional support.

CA-P PREVENTION

OUTCOME: The patient and family will have awareness of risk factors associated with the development of cancer and be able to access health activities.

STANDARDS:

1. Explain that the use of tobacco is a major risk factor for many and diverse types of cancer.
2. Discuss the need to use sunscreens or reduce sun exposure.
3. Discuss reduction to exposure of chemicals as appropriate.
4. Discuss other preventive strategies as currently determined by the American Cancer Society.
5. Discuss the importance of health surveillance and routine health maintenance and recommended screening procedures for a patient of this age/sex (PAP smears, colonoscopy, BSE, TSE, PSA, etc.).
6. Emphasize the importance of early detection of cancer in cancer cure. Encourage the patient to come in early if signs of cancer (unexpected weight loss, fatigue, GI bleeding, new lumps or bumps, nagging cough or hoarseness, change in bowel or bladder habits, changes in warts or moles, sores that don't heal, etc.) are detected.

CA-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of 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 narcotics and other medications may be helpful to control pain and the symptoms associated with pain or nausea and vomiting.
3. Explain non-pharmacologic measures that may be helpful with pain control.

CA-REF REFERRAL

OUTCOME: The patient/family will understand referral and contract health services process and will make a plan to follow-up with contract health services.

STANDARDS:

1. Emphasize that referrals to outside providers by Indian Health Service primary providers typically will be processed by Contract Health Services.
2. Explain the procedure for the referral to the private sector is usually based on a priority system and/or waiting list.
3. Explain that coverage by insurance companies and Medicare/Medicaid packages will be utilized prior to contract health service funds in most cases. The Indian Health Service is a payer of last resort.
4. Discuss the rules/regulations of Contract Health Services.
5. Refer as appropriate to community resources for Medicaid/Medicare enrollment, i.e., benefits coordinator, social services. **Refer to [EOL-LW](#).**
6. Discuss the importance of follow-up care and the requirement to notify contract health services of any future appointments and procedures by the private sector. **Referrals are for one visit only**, unless otherwise specified. Future and/or additional referrals must be approved prior to the appointment.

CA-TE TESTS

OUTCOME: The patient /family will understand the conditions under which testing is necessary and the specific test(s) to be performed, 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 risks associated with the alternatives, i.e., risk of non-testing.

STANDARDS:

1. Explain that tests may be necessary for diagnosis or staging of cancer and follow-up therapy. Discuss the procedure for the test to be performed, 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.
3. Explain any preparation for testing that is necessary, i.e., NPO status, bowel preps.

CA-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 treatments may prolong the patient's life and improve the quality of life by increasing patient comfort or curing of the disease process.
5. Discuss therapies that may be utilized including chemotherapy, surgical debulking or removal of tumor and radiation therapy as appropriate.
6. Explain that various treatments have their own inherent risks, side effects and expected benefits. Explain the risk/benefit of treatment/non-treatment.

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 (loss of function, loss of speech, confusion, loss of independence, etc.).
2. Discuss the importance of following the prescribed treatment plan including physical therapy, medications and rehabilitation in maximizing potential.

CVA-DP DISEASE PROCESS

OUTCOME: The patient will have an understanding of 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 (weakness, numbness, confusion, slurred speech, episodes of “blacking out”, etc.).
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 verbalize understanding 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 verbalize an understanding of 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, complying with medication therapy, adhering to dietary modifications, and maintaining an appropriate activity/rest balance.
3. Review the symptoms which should be reported (symptoms more frequent or occurring during rest, symptoms lasting longer, etc.).

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 have an understanding of 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 have an understanding of 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 adherence to the medication regimen.

CVA-N NUTRITION

OUTCOME: The patient/family will have an understanding of 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 and 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 (remove throw rugs, install bars in tub/shower, secure electrical cords, etc.).
3. Stress importance and proper use of mobility devices (cane, walker, wheel chair).

CVA-TE TESTS

OUTCOME: The patient/family will have an understanding of 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 (CT, MRI, angiography, etc.).
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 have an understanding of 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 (angioplasty, carotid endarterectomy, etc).
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-C COMPLICATIONS

OUTCOME: The patient and family will understand how to avoid the complications of chemical dependency and develop a plan to slow the progression of the disease by adherence with a prescribed daily program.

STANDARDS:

1. Review the effects that the different chemicals have on the body. Emphasize the long-term effects of continued use of the patient's specific dependency/substance abuse.
2. Discuss the symptoms indicative of progression of disease.
3. Review the effects of chemical dependency on lifestyle and on all family members.

CD-DP DISEASE PROCESS

OUTCOME: The patient and family will understand the disease process of chemical dependency/substance abuse and develop motivation for change.

STANDARDS:

1. Review the current factual information re: the patient's specific chemical dependency/substance abuse.
2. Provide the patient with an opportunity for discussion and referral for the purpose of acknowledging and understanding the diagnosis of chemical dependency.
3. Explain addiction, dependency, and co-dependency.
4. Discuss a plan of care that will achieve the goal of sobriety and freedom from use of mood altering chemicals.

CD-EX EXERCISE

OUTCOME: The patient and family will understand the role of an exercise program as part of rehabilitation and maintenance of sobriety.

STANDARDS:

1. Refer to [WL-EX](#).
2. Review the benefits of regular exercise, i.e., reduced stress, weight control, increased self-esteem and overall sense of wellness.
3. Assist the patient in development of a reasonable plan for regular exercise.

CD-FU FOLLOW-UP

OUTCOME: The patient and family will participate in a prevention program such as a support group to help prevent relapse.

STANDARDS:

1. Discuss the positive attributes of AA, ALANON, and/or related groups.
2. Review the nature of chemical dependency as a primary, chronic, and arrestable disease.
3. Review the treatment and support options available to the patient and family.

CD-HM HOME MANAGEMENT

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

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Discuss the importance of appropriate relationships, i.e., the possible need to sever old, unhealthy relationships and form new healthy relationships.

CD-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

CD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient and family will understand that chemical dependency is a primary, chronic, and arrestable disease and will develop a plan to modify behaviors that propagate chemical dependency or substance abuse.

STANDARDS:

1. Discuss the patient's use/abuse of chemicals.
2. Discuss patient and/or family attitudes towards dependency or substance abuse and mechanisms to modify those attitudes and behavior.
3. Discuss the power of addiction and the need to utilize family and community resources to help control this addiction.
4. Explain that both patient and family need to acknowledge, admit, and develop a plan to seek help.
5. Review treatment options available.

CD-M MEDICATIONS

OUTCOME: If applicable, the patient and family will understand the importance of complying with a prescribed medication regimen.

STANDARDS:

1. Review the mechanism of action of the prescribed medication.
2. Discuss the side effects of the prescribed medications.
3. Emphasize the importance of not self-medicating for any purpose.
4. Review OTC medications (e.g., cough syrup) that contain ETOH/drug additives and the signs/symptoms of innocent ingestion.

CD-N NUTRITION

OUTCOME: The patient and family will understand the importance of a nutritionally balanced diet in relationship to recovery from chemical dependency. Patients will strive to acquire and maintain a healthy weight.

STANDARDS:

1. Assess the patient's current nutritional habits. Review how these habits might be improved.
2. Discuss the importance of the food guide pyramid, regular eating habits, and the possible need to increase carbohydrates.
3. Emphasize the importance of limiting snack foods, fatty foods, fatty red meats, reducing sodium consumption, and adding more fresh fruits, fresh vegetables, and fiber to the diet.
4. Emphasize the necessary component – WATER – in a healthy diet. Reduce the use of colas and coffee.
5. Review the symptoms of hypoglycemia for patients at risk.

CD-P PREVENTION

OUTCOME: Make the patient aware of the dangers of chemical dependency and substance abuse to promote a drug-free lifestyle.

STANDARDS:

1. Increase awareness of risk behaviors which can lead to chemical dependency, i.e., experimentation with chemicals can lead to addiction and there may be a progression to poly-drug use.
2. Discuss how chemical dependency adversely affects lifestyle.

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, etc.
2. Explain that diagnostic testing may be required to determine the etiology.

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 comply 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 adherence 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 have an understanding of how nutrition might affect chest pain.

STANDARDS:

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

CP-TE TESTING

OUTCOME: The patient/family will have an understanding of 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, etc.

CHN-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of keeping routine well child visits.

STANDARDS:

1. Discuss that well child visits are important to follow growth and development, screen for disease and update immunizations.
2. Inform the patient/family of the timing of the next well child visit.
3. Discuss the procedure for making appointments.

CHN-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent(s) will have a basic understanding of a newborn's growth and development.

STANDARDS:

1. Discuss the various newborn reflexes.
2. Explain the limits of neuromuscular control in newborns.
3. Review the myriad of "noises" newborns can make and how to differentiate between normal sounds and signs of distress.
4. Review the limited wants of newborns— to be dry, fed and comfortable.
5. Discuss the other newborn aspects— sleeps about 20 hours, may have night and day reversed, colic and fussiness, knows mother better than father.

CHN-I INFORMATION

OUTCOME: Parents/family will have an understanding of newborn health and wellness issues.

STANDARDS:

1. Bowel habits
 - a. Discuss the difference in frequency, consistency, texture, color, and odor of stools of breast or bottle fed newborns. Stress that each newborn is different.
 - b. Review constipation. Strongly discourage the use of enemas or homemade preparations to relieve constipation.
 - c. Review diarrhea protocols -- clear liquids, when to come to the clinic.
 - d. Discuss normal I/O (7-8 wet and/or dirty diapers by the 4th to 5th day of life).
2. Stress the dangers of fever (>101 degrees Fahrenheit) in the newborn period and the importance of seeking immediate medical care. **Refer to [NF](#).**
3. Discuss that rectal temperature is a reliable method of temperature measurement in newborns.
4. Discuss the option of circumcision and care of the circumcised and uncircumcised penis.
5. Discuss newborn hygiene (bathing, cord care, avoidance of powders, etc.).
6. Discuss symptoms of jaundice and icterus and when to seek medical care.
7. Discuss the immunization schedule and when the infant should receive his/her first immunization. **Refer to [IM](#).**
8. Discourage use of medications in the newborn period.

CHN-L PATIENT INFORMATION LITERATURE

OUTCOME: The parent/family will receive written information about child health issue.

STANDARDS:

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

CHN-N NUTRITION

OUTCOME: The parent/family will have an understanding of the various methods of feeding a baby in order to ensure good nutrition and adequate growth.

STANDARDS:

1. Discuss the options of breastfeeding versus bottle feeding. **Refer to [BF](#).**
2. Discuss that solids are not needed until 4-6 months of age.
3. Discourage the use of cereals added to formula except when specifically recommended by the health care provider.
4. Emphasize that nothing should be given from the bottle but formula, breast milk, water, or electrolyte solutions, i.e., no caffeinated beverages or other soft drinks.
5. Review formula preparation and storage.
6. Review proper technique and position for bottle feeding, i.e., no propping of bottles.

CHN-PA PARENTING

OUTCOME: The parent/family will cope in a healthy manner to the addition of a new family member.

STANDARDS:

1. Discuss the common anxieties of new parents.
2. Review some of the changes of adding a new baby to the household.
3. Review the sleeping and crying patterns of a new baby.
4. Emphasize the importance of bonding and the role of touch in good emotional growth.
5. Emphasize that fatigue, anxiety, and frustration are normal and temporary. Discuss coping strategies.
6. Discuss sibling rivalry and some techniques to help older siblings feel important.
7. Review the community resources available for help in coping with a new baby.

CHN-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

1. Review the dangers of leaving a newborn unattended. Discuss the need to require ID from people presenting themselves in an official capacity.
2. Stress the use of a properly secured car seat EVERY TIME the newborn rides in a vehicle.
3. Discuss the dangers posed by--open flames, closed-up cars, siblings, plastic bags, tossing the baby in the air, second-hand cigarette smoke and shaken-baby syndrome.
4. Illustrate the proper way to support a newborn's head and back.
5. Explain that SIDS is decreased by back or side-lying.
6. Stress the importance of carefully selecting child-care settings to assure child safety.

CHN-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 infants when exposed to cigarette smoke either directly or via second-hand smoke.
4. Discuss that infants who live in home where someone smokes in the home are three times more likely to die of SIDS than infants who do not live in a home in which someone smokes.
5. 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.
6. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
7. Encourage smoking cessation or at least never smoking in the home or car.

CHI-FU FOLLOW UP

OUTCOME: The patient/family will understand the importance of keeping routine well child visits.

STANDARDS:

1. Discuss that well child visits are important to follow growth and development, screen for disease and update immunizations.
2. Inform the patient/family of the timing of the next well child visit.
3. Discuss the procedure for making appointments.

CHI-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent(s) will have an understanding of the biologic and developmental changes and achievements during infancy and provide a nurturing environment to achieve normal growth and development.

STANDARDS:

1. Review the expected weight and height changes.
2. Review the improvements in neuromuscular control--visual acuity and motor control.
3. Discuss psycho-social development--prevalence of narcissism and acquisition of trust.
4. Discuss cognitive development--active participation with the environment fosters learning.
5. Review adaptive behaviors:
 - a. Smiles by 8 weeks.
 - b. Show interest in environment by 3 months.
 - c. Laughs by 4 months.
 - d. Is very personable by 6 months.
 - e. Understands simple directions by 6 months.
 - f. Imitates by 8 months.
 - g. Plays peek-a-boo, patty-cake by 10 months.

CHI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about child health issue.

STANDARDS:

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

CHI-N NUTRITION

OUTCOME: The parent(s) will understand the changing nutritional needs of an infant.

STANDARDS:

1. Discuss the schedule for introducing solids and juices at 4-5 months of age, and how to accomplish first spoon feeding. Explain that solids should not be fed from a bottle or infant feeder but from a spoon.
2. Review breast-feeding and discuss current information on the use of vitamin and iron supplements when breast-feeding.
3. Review formula preparation and storage and proper technique and position for bottle feeding (no propping bottles in bed).
4. Discuss age appropriate intake (ounces/day) and stress the dangers of overfeeding.
5. Discuss weaning, transition from bottle to cup. Emphasize the effects of “baby bottle tooth decay”.
6. Discuss waiting 3-4 days between additions of new foods to identify food allergies.
7. Discuss as appropriate the recommendations for fluoride supplementation in non-fluoridated water areas. (Currently no fluoride supplementation is recommended for infants under 6 months of age.)

CHI-PA PARENTING

OUTCOME: The parent(s) and family will adapt in a healthy manner to the growth and development of the infant.

STANDARDS:

1. Discuss how home life is beginning to settle down.
2. Review basic nurturing skills: spending time with the infant, continued importance of touch, involving father in care and nurturing.
3. Emphasize that increasing mobility necessitates discipline.
4. Encourage stimulation of the infant (auditory, tactile, visual).
5. Stress importance of regular well child care and immunizations.
6. Review the community resources available for help in coping with an infant.

CHI-S SAFETY AND INJURY PREVENTION

OUTCOME: The parent(s) will understand principles of injury prevention and plan a safe environment.

STANDARDS:

1. Explain that accidents are a major cause of death.
2. Stress that the infant's increasing mobility requires additional vigilance to the dangers of aspiration, suffocation, falls, poisonings, burns, motor vehicle crashes and other accidents.
3. Explain that walkers are a source of serious injury and often delay walking.
4. Explain that SIDS is decreased by back-lying.
5. Child-proof the home. **Refer to [WL-S](#).**
6. Emphasize the importance of carefully selecting child-care settings to assure child safety.

CHI-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 infants when exposed to cigarette smoke either directly or via second-hand smoke.
4. Discuss that infants who live in home where someone smokes in the home are three times more likely to die of SIDS than infants who do not live in a home in which someone smokes.
5. 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.
6. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
7. Encourage smoking cessation or at least never smoking in the home or car.

CHI - W WEANING

OUTCOME: The parent/family will have an understanding of methods to effectively wean the child from breastfeeding or bottle.

STANDARDS:

1. Discuss appropriate reasons for weaning the infant from breastfeeding or bottle.
2. Explain readiness signs of weaning that the infant may display.
3. Explain the process of weaning, i.e., replace one feeding at a time with solids or cup.
4. Explain social ways to replace breastfeeding or bottle-feeding, i.e., reading books together, playing with toys, cuddling together.
5. Explain that infants should be weaned from the bottle by 12 months of age.
6. Refer to community resources as appropriate.

CHT-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of keeping routine well child visits.

STANDARDS:

1. Discuss that well child visits are important to follow growth and development, screen for disease and update immunizations.
2. Inform the patient/family of the timing of the next well child visit.
3. Discuss the procedure for making appointments.

CHT-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent(s) will have an understanding of the rapidly changing development of the inquisitive and independent toddler and plan to nurture normal growth and development.

STANDARDS:

1. Explain the toddler's intense need to explore.
2. Review appropriate ways of disciplining toddlers. Provide positive alternatives to undesirable behaviors. Toddlers often attempt to control others with temper tantrums, negativism and obstinacy. Encourage parents to be consistent in discipline.
3. Discuss toilet training methods and indicators of toilet training readiness such as the ability to walk, complaining of wet or dirty diapers, asking to go to the toilet, etc.
4. Review the importance of allowing for positive emotional growth. Touch is still important. Fears may develop during this time.
5. Review the need for good dental hygiene.
6. Discuss the need for continued well child care.

CHT-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about child health issue.

STANDARDS:

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

CHT-N NUTRITION

OUTCOME: The parent(s) will have an understanding of the nutritional needs of the toddler and the frustrations that can surround mealtime.

STANDARDS:

1. Discuss the varying levels of mastery of cups and utensils.
2. Review the dangers posed by continued use of the bottle beyond one year of age such as baby bottle tooth decay, elongated midface, delayed speech, ear infections, etc.
3. Explain that most toddlers manifest a decreased nutritional need. Discuss that toddlers become fussy eaters with strong food preferences. Discuss appropriate diet (balance diet over the week -- do not struggle to balance every meal, appropriate serving size is one tablespoon per year of age). Explain that it is very important to avoid the temptation to replace healthy foods with candy, cookies, etc.
4. Avoid foods that are choking hazards through age 4 (unpeeled grapes, unpeeled apples, orange slices, nuts, popcorn, pickles, carrot sticks, celery sticks, hard candies and gum, wieners, chicken drum sticks, and peanut butter).
5. Encourage a relaxed mealtime atmosphere.
6. Encourage healthy choices for meals and snacks.

CHT-PA PARENTING

OUTCOME: The parent(s) will understand challenges of parenting a toddler and will continue to provide a nurturing environment for growth and development.

STANDARDS:

1. Emphasize that the toddler continues to demand much of the parent(s) time, and increasing mobility and independence requires increased supervision.
2. Discuss the common toddler behaviors that can cause parental frustration— constant demands, saying “no”, struggle for autonomy, inability to share, and boundless energy.
3. Discuss the parental need for sharing the toddler experience.
4. Reinforce the need for adult companionship, periodic freedom from child-rearing responsibilities, and nurturing the marital relationship.
5. Stress that weariness, frustration, and exasperation with a toddler are normal. Sometimes it is difficult to love toddlers when they are not asleep.
6. Provide stimulating activities (reading to the child, coloring with the child, etc) as alternatives to TV watching, which should not exceed one hour per day. The attention span of a toddler is about 5-10 minutes.

CHT-S SAFETY AND INJURY PREVENTION

OUTCOME: The parent(s) will understand the principles of injury prevention and plan to provide a safe environment.

STANDARDS:

1. Review that accidents are the leading cause of death in this age group due to the toddler's increased mobility and lack of awareness of environmental dangers.
2. Stress additional vigilance to the dangers of drowning, open flames, charcoal pans, aspiration, suffocation, falls, poisonings, animal bites, electrocution and motor vehicle crashes. **Refer to [WL-S](#).**
3. Discuss foods which are choking hazards (unpeeled grapes, unpeeled apples, orange slices, nuts, popcorn, pickles, carrot sticks, celery sticks, hard candies and gum, wieners, chicken drum sticks, and peanut butter).
4. Review continued need for child safety seats in automobiles. (As of March 2001 the American Academy of Pediatrics recommends that children remain in child safety seats until the age of 8 years AND 80 pounds.)
5. Review indications for and proper use of syrup of ipecac.
6. Emphasize the importance of carefully selecting child-care settings to assure child safety.

CHT-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 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 children when exposed to cigarette smoke either directly or via second-hand smoke, i.e., increased colds, asthma, ear infections, pneumonia.
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. **Refer to [TO](#).**

CHT-W WEANING

OUTCOME: The parent/family will have an understanding of methods to effectively wean the child from breastfeeding or bottle.

STANDARDS:

1. Discuss appropriate reasons for weaning the infant from breastfeeding or bottle.
2. Explain readiness signs of weaning that the infant may display.
3. Explain the process of weaning, i.e., replace one feeding at a time with solids or cup.
4. Explain social ways to replace breastfeeding or bottle-feeding, i.e., reading books together, playing with toys, cuddling together.
5. Explain that infants should be weaned from the bottle by 12 months of age to decrease the risk of baby bottle tooth decay, ear infections, delayed speech, etc.
6. Refer to community resources as appropriate.

CHP-FU FOLLOW UP

OUTCOME: The patient/family will understand the importance of keeping routine well child visits.

STANDARDS:

1. Discuss that well child visits are important to follow growth and development, screen for disease and update immunizations.
2. Inform the patient/family of the timing of the next well child visit.
3. Discuss the procedure for making appointments.

CHP-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent will understand the growth and development of a preschool age child and plan to provide a nurturing environment.

STANDARDS:

1. Discuss characteristics such as a short attention span, imagination, high mobility and learning through play and peers.
2. Discuss the most common fears of this age; separation from parents, mutilation, immobility, the dark and pain.
3. Discuss that night terrors are a normal developmental phenomenon and they are not indicative of underlying problems.
4. Review age appropriate physical growth and development.

CHP-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about child health issue.

STANDARDS:

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

CHP-N NUTRITION

OUTCOME: The parent will understand the nutritional needs of the preschooler.

STANDARDS:

1. Review the basics of a balanced diet. Explain that serving sizes for children are smaller than for adults – about one tablespoon of each food for each year of age.
2. Discuss the relationships between childhood obesity and adult obesity. Relate the risk of diabetes to obesity.
3. Emphasize the importance of healthy snack foods, limit fatty foods and refined sugars, increase fresh fruits, fresh vegetables and fiber.
4. Explain the need for a structured meal time due to short attention span and high mobility.

CHP-PA PARENTING

OUTCOME: The parent will understand the transition from toddler to school age and plan to provide a nurturing environment for is period of development.

STANDARDS:

1. Emphasize that children at this age are striving for greater independence and that in so doing they often test parental boundaries. Emphasize the importance of proper discipline.
2. Explain the need for preschoolers to have group interaction with children of similar age and gender. Explain the importance of teaching children to respect others and accept their differences. Discourage bullying and belittling behaviors.
3. Emphasize that preschool growth is at a rapid pace. Their rapidly increasing mobility and agility combined with their limited problem solving ability means that they need adult supervision.
4. Discuss the need for parental discretion as the child's vocabulary is expanding. Protect your children from language you don't want them to repeat, including television, music, conversations, etc.
5. Discuss common fears of this age and the need for parental support.

CHP-S SAFETY AND INJURY PREVENTION

OUTCOME: The parent will develop a plan for injury prevention.

STANDARDS:

1. Explain that with increasing independence children of this age are at risk for accidents. Continue vigilance to dangers of drowning, open flames, suffocation, poisonings, animal bites, electrocution and motor vehicle crashes.
2. Emphasize the need for protective equipment, i.e., bike helmets, knee pads, elbow pads etc.
3. Emphasize continued need for passenger safety devices. Children still need booster seats through 8 years of age and 80 pounds.
4. Discuss stranger safety and personal safety, i.e., private parts of their body.
5. Emphasize the importance of teaching the child how to cross the street safely.
6. Discuss the importance of teaching the child parent's name, complete address including state, complete telephone number including area code, and emergency phone numbers (911, etc.).
7. Encourage participation in programs which photograph and fingerprint children for identification purposes.
8. Emphasize the importance of carefully selecting child-care settings to assure child safety.

CHP-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 children when exposed to cigarette smoke either directly or via second-hand smoke, i.e., increased colds, asthma, ear infections, pneumonia.
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.

CHS-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of keeping routine well child visits.

STANDARDS:

1. Discuss that well child visits are important to follow growth and development, screen for disease and update immunizations.
2. Inform the patient/family of the timing of the next well child visit.
3. Discuss the procedure for making appointments.

CHS-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent(s) will have an understanding of the growth and development of the school-aged child.

STANDARDS:

1. Explain that this is a time of gradual emotional and physical growth. Physical and mental health is generally good.
2. Discuss how coordination and concentration improve allowing participation in sports.
3. Review the increasing importance of hygiene.
4. Discuss prepubescent body changes and the accompanying emotions.
5. Review the information needed to explain menses and nocturnal emissions (as appropriate).
6. Encourage age-appropriate discussions of sexuality, birth control and sexually transmitted diseases. **Refer to [CHS-SX](#)**

CHS-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about child health issue.

STANDARDS:

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

CHS-N NUTRITION

OUTCOME: The parent(s) will understand the changing nutritional needs of a school-aged child.

STANDARDS:

1. Review the basics of a balanced diet.
2. Discuss how childhood obesity is increasingly prevalent in school-aged children and emphasize its relationship to adult obesity and emotional well-being. Relate the risk of diabetes to obesity.
3. Discuss the child's predilection for junk food. Stress ways to improve the diet by replacing empty calories with fresh fruits, nuts and other wholesome snacks.

CHS-PA PARENTING

OUTCOME: The parent(s) will have an understanding of the "growing away" years and make a plan to maintain a healthy relationship with the child.

STANDARDS:

1. Discuss how peer influence becomes increasingly important.
2. Review age-specific changes:
 - a. Age 6: Mood changes, need for privacy
 - b. Age 7-10: Increase in peer involvement. Experimentation with potentially harmful activities and substances may begin.
 - c. Age 11-12: Increase in stormy behavior. Sexual maturation necessitates adequate and accurate sex education.
3. Provide stimulating activities as an alternative to watching TV. TV watching should be limited to one hour per day.

CHS-S SAFETY AND INJURY PREVENTION

OUTCOME: The parent(s) will identify safety concerns and make a plan to prevent injuries as much as is possible.

STANDARDS:

1. Review that motor vehicle crashes are the most common cause of injury and death in this age group. Encourage the use of seat belts. Child safety seats are recommended for children until they are 8 years old AND weigh 80 pounds.
2. Review traffic safety.
3. Review personal safety - approaches by strangers, sexual molestation, etc.
4. Discuss age-appropriate recreational activities. (Most children in this age group lack the coordination to operate a motor vehicle.)
5. Discuss the appropriate use of personal protective equipment when engaging in sports (helmets, knee and elbow pads for bicycling and roller blading; life vests for water sports; helmets and protective body gear for horseback riding, etc.).

CHS-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 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 children when exposed to cigarette smoke either directly or via second-hand smoke, i.e., increased colds, asthma, ear infections, pneumonia.
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. **Refer to [TO](#).**

CHS-SX SEXUALITY

OUTCOME: The parent(s) and adolescent will understand that children are maturing at a younger age, necessitating education about sexual safety at a younger age.

STANDARDS:

1. Explain the physical changes that result from increased hormonal activity. Discuss that this is happening at a younger age.
2. Discuss as appropriate the anatomy and physiology of the male/female reproductive tract. **Refer to [WL-SX](#).**
3. Explain that as a general rule, menarche occurs within two years of thelarche (breast development).
4. Discuss the elements of a positive, nurturing interpersonal relationship versus a potentially abusive relationship.
5. Review the benefits of abstinence and self-respect including physical and emotional benefits, i.e., negating the risk of STDs, and pregnancy, dramatically reducing the risk of cervical cancer, having the first sexual encounter be in the context of a stable, loving relationship.
6. Identify the community resources available for sexuality counseling.

CHS-TO TOBACCO

OUTCOME: The patient/family will understand the dangers of tobacco or nicotine use and make a plan to never initiate tobacco use or if already using tobacco make a plan to quit.

STANDARDS:

1. Review the current factual information regarding tobacco use. Explain that tobacco use in any form is dangerous.
2. Explain nicotine addiction.
3. 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, etc.
4. Review the effects of tobacco use on all family members- financial burden, second-hand smoke, greater risk of fire and premature.
5. Explain dependency and co-dependency.
6. Discuss that tobacco use is a serious threat to health. If the patient is already using tobacco, encourage tobacco cessation and refer to cessation program. **Refer to [TO](#).**

CHA-CD CHEMICAL DEPENDENCY

OUTCOME: The patient/family will understand the dangers posed by use of tobacco, alcohol, street drugs or abuse of prescription drugs.

STANDARDS:

1. Explain that adolescence is a high-risk time for using drugs and other risky behaviors.
2. Describe some of the possible dangers of illicit drug use, including but not limited to:
 - a. Marijuana is known to interfere with the actions of male hormones and may reduce fertility and male secondary sex characteristics.
 - b. Cocaine, methamphetamine (“speed”), and other stimulant use is often associated with heart attacks, strokes, and kidney failure.
 - c. Narcotics cause sedation, constipation, and significant impairment of ability to think.
 - d. All drugs of abuse impair judgment and dramatically increase the risk of behaviors which lead to AIDS, hepatitis, and other serious infections, many of which are not curable.
 - e. Illicit drug use often results in arrest and imprisonment, creating a criminal record which can seriously limit the offender’s ability to get jobs, education, or participate in government programs.
3. Explain that nicotine, found in smoke and smokeless tobacco products, is an extremely addictive drug and that almost everyone who uses tobacco for very long will become addicted. Risks of tobacco use include:
 - a. Emphysema and severe shortness of breath which often will limit the patient’s ability to participate in normal activities such as sports, sex, and walking short distances.
 - b. Greatly increased risk of heart attacks, strokes, and peripheral vascular disease.
 - c. Significant financial cost. (Smoking one pack of cigarettes per day at \$3.00 per pack will cost almost \$1,100.00 per year. Suggest that there a lot of things the patient may prefer to do with that much money.)
 - d. Cancer of the lung, bladder, and throat (smoking) and of the lip and gum (smokeless tobacco). These tumors are typically very aggressive and often cannot be successfully treated.
4. Explain that alcohol use is a major cause of illness and death in the United States and that addiction is common. Some of the risks of alcohol use are:

PATIENT EDUCATION PROTOCOLS:CHILD HEALTH – ADOLESCENT (12-18 years)

- a. Significant impairment of judgment and thinking ability leading to behaviors which the patient might not otherwise engage in, such as indiscriminate sex, fighting, and use of other drugs.
- b. Liver disease, up to and including complete liver failure and death.
- c. Arrest and imprisonment for alcohol-related behaviors such as drunken driving or fighting.
- d. Loss of employment, destroyed relationships with loved ones, and serious financial problems.

CHA-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of keeping routine well visits.

STANDARDS:

1. Discuss the reasons for well visits.
2. Inform the patient/family of the timing of the next well visit.
3. Discuss the procedure for making appointments.

CHA-GD GROWTH AND DEVELOPMENT

OUTCOME: The patient/family will have an understanding of the physical and emotional changes that are a natural part of adolescence.

STANDARDS:

1. Explain that adolescence is a time of rapid body growth. This often results in awkwardness as the brain is adjusting to the new body size.
2. Discuss the natural increase in sex hormones during adolescence. Explain that this often results in an increased interest in members of the opposite sex. Encourage abstinence.
3. Explain that emotional and social maturity often do not keep pace with physical maturity. It is very important to keep open lines of communication between parents and teenagers.
4. Explain that puberty and the associated growth spurt begins and ends at an earlier age in girls than in boys.

PATIENT EDUCATION PROTOCOLS:CHILD HEALTH – ADOLESCENT (12-18 years)

CHA-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about adolescent health issue.

STANDARDS:

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

CHA-N NUTRITION

OUTCOME: The parent(s) and adolescent will relate nutrition to health promotion and disease prevention.

STANDARDS:

1. Stress the importance of reducing fats, sugars, and starch to avoid obesity and diabetes and subsequent self-image problems. Emphasize the role peers play in food intake. **Refer to [WL-N](#).**
2. Emphasize the importance of not skipping meals, especially breakfast.
3. Discuss calcium intake, including its role in preventing osteoporosis.

CHA-PA PARENTING

OUTCOME: The parent/family and adolescent will understand the transitional phase of adolescence from childhood to adulthood.

STANDARDS:

1. Discuss the teenager's changing self-image and the effect of peer pressure.
2. Stress the importance of communicating (especially LISTENING) and providing a supportive environment.
3. Discuss how fluctuating hormone levels affect emotions. Be alert for significant changes in behavior which may indicate depression.
4. Provide an environment which allows for increased independence and decision-making. Emphasize the importance of completing adequate education.
5. Encourage open lines of communication between parents and community role models.
6. Explain the importance of teaching adolescents to respect others and accept their differences. Discourage bullying and belittling behaviors.

CHA-S SAFETY AND INJURY PREVENTION

OUTCOME: The parent and adolescent will understand the principles of injury prevention and avoidance of risk behaviors.

STANDARDS:

1. Refer to [CD](#) and [TO](#).
2. Promote driving education courses.
3. Promote use of seat belts.
4. Review personal safety strategies (sexual molestation, strangers, chat rooms, etc.).
5. Review self-destructive behaviors (suicidal gestures and comments, improper/inappropriate use of firearms, gangs, cults, hazing, alcohol and substance use/abuse).

CHA-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 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 children when exposed to cigarette smoke either directly or via second-hand smoke, i.e., increased colds, asthma, ear infections, pneumonia.
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. **Refer to [TO](#).**

CHA-SX SEXUALITY

OUTCOME: The parent(s) and adolescent will understand the challenges of adolescent sexual development.

STANDARDS:

1. Explain the physical changes that result from increased hormonal activity.
2. Discuss the elements of a positive, nurturing interpersonal relationship versus a potentially abusive relationship.
3. Review the need for continued information sharing regarding sexuality, birth control and STDs.
4. Discuss as appropriate the anatomy and physiology of the male/female reproductive tract. **Refer to [WL-SX](#).**
5. Review the benefits of abstinence and self-respect including physical and emotional benefits, i.e., negating the risk of STDs, and pregnancy, dramatically reducing the risk of cervical cancer, having the first sexual encounter be in the context of a stable, loving relationship.
6. Identify the community resources available for teenage sexuality counseling.

CHA-TO TOBACCO

OUTCOME: The patient/family will understand the dangers of tobacco or nicotine use and make a plan to never initiate tobacco use or if already using tobacco make a plan to quit.

STANDARDS:

1. Review the current factual information regarding tobacco use. Explain that tobacco use in any form is dangerous.
2. Explain nicotine addiction.
3. 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, etc.
4. Review the effects of tobacco use on all family members: financial burden, second-hand smoke, greater risk of fire and premature death.
5. Explain dependency and co-dependency.
6. Discuss that tobacco use is a serious threat to health. If the patient is already using tobacco, encourage tobacco cessation and refer to cessation program. **Refer to [TO](#).**

CB-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient will verbalize a basic understanding of the anatomy of the female reproductive system and how it relates to the physiology of labor and delivery.

STANDARDS:

1. Explain the anatomy of the female reproductive system in pregnancy, i.e., labia, vagina, cervix, uterus, placenta, umbilical cord, amniotic sac and fluid, pelvic muscles and bones.
2. Explain that “labor” is the contraction of the uterine muscles.
3. Relate the changes that occur in the female reproductive system as labor is initiated and progresses:
 - a. First Stage
 - i. The early or latent phase is characterized by irregular contractions or regular contractions without changes in the cervix. Emphasize that this may last for days or weeks.
 - ii. The active phase is characterized by regular contractions with cervical dilatation.
 - iii. The transition phase is the final part of the first stage of labor during which the cervix becomes fully dilated.
 - b. The Second Stage starts when the cervix is fully dilated and ends at the time of delivery of the baby during which the baby passes through the birth canal.
 - c. The Third Stage of labor is the time between the delivery of the baby to the time of delivery of the placenta.

CB-C COMPLICATIONS

OUTCOME: The patient will verbalize understanding that a normal labor and delivery has the potential to become abnormal and present complications at any time.

STANDARDS:

1. Explain that complications may necessitate the use of special equipment, medications and possibly cesarean section to facilitate safe and expedient delivery of the baby.
2. Explain that it is impossible to predict who will or will not have a complication during labor.
3. Explain that despite appropriate medical care, not all pregnancies result in normal/healthy babies.

CB-EX EXERCISES, RELAXATION & BREATHING

OUTCOME: The patient will be able to demonstrate the relaxation and breathing exercises to be utilized during the stages of labor and delivery.

STANDARDS:

1. Explain, demonstrate, and supervise the return demonstration of relaxation techniques, i.e., muscle contraction/relaxation, focusing, touching.
2. Explain, demonstrate, and supervise the return demonstration of breathing exercises appropriate to each stage of labor. Examples may include:
 - a. Slow-paced (slow/deep chest) for early labor.
 - b. Modified-paced breathing (light chest breathing) for active labor.
 - c. Pattern paced breathing (almost no chest breathing) for transition labor to inhibit pushing.
 - d. Method of breathing when pushing during delivery.

CB-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of postpartum and newborn follow up visits.

STANDARDS:

1. Emphasize the importance of keeping appointments for routine postpartum and newborn follow-up.
2. Discuss the procedure for obtaining postpartum and newborn follow-up appointments.

CB-L LITERATURE

OUTCOME: The patient and/or delivery partner/coach will receive written information about childbirth.

STANDARDS:

1. Provide the patient and/or delivery partner/coach with written patient information literature on childbirth.
2. Discuss the content of patient information literature with the patient and/or labor partner/coach.

CB-LB LABOR SIGNS

OUTCOME: The patient and/or labor partner/coach will have an understanding of the signs of true labor and will understand when to come to the hospital.

STANDARDS:

1. Explain the difference between early labor and false labor (Braxton-Hicks contractions).
2. Emphasize the importance of immediate evaluation for any suspected amniotic fluid leak. Explain that prolonged rupture of membranes can be dangerous to the baby and the mother.
3. Discuss the appropriate time for this patient to present to the hospital as related to frequency and duration of contractions, etc.
4. Explain that the patient should come to the hospital immediately for rupture of membranes, heavy bleeding, severe headaches, severe swelling, or decreased fetal movement.

CB-M MEDICATIONS

OUTCOME: The patient will verbalize a basic understanding of the use medications that may be used during labor and/or delivery.

STANDARDS:

1. Explain that there are medications which can be used to make the cervix more ready for labor. Explain the route of administration for the medication to be used.
2. Explain that medication may be given to stimulate or enhance uterine activity. Explain the route of administration of the medication to be used.
3. Discuss common and important side-effects of the medication to be used. Discuss side-effects which should be immediately reported to the health care provider.

CB-OR ORIENTATION

OUTCOME: The patient and labor partner/coach will be familiar with the labor and delivery suite, nursery and postpartum areas of the hospital.

STANDARDS:

1. Familiarize the patient and labor partner/coach with the Obstetrical Department of the hospital.
2. Explain the hospital policy regarding visiting hours and regulations, meal times, assessment times and physician rounds, as applicable.
3. Review the need for a plan for the patient/labor partner, emphasizing the need to come to the hospital at an appropriate time during labor.
4. Relate the events to be expected immediately after the baby is born.
 - a. Repair of lacerations/episiotomy and the after-care required.
 - b. Vital signs and monitoring of the uterus, vaginal discharge and urination, including frequent massage of the mother's uterus.
 - c. Assessment and observation of the baby, including vital signs and blood glucose monitoring as indicated.
 - d. The policy of rooming-in.
5. Explain hospital policy for the birth certificate, including how the baby's surname will be recorded.
6. Discuss the items to bring to the hospital - CAR SEAT, toiletries, gown and robe, clothes to wear when discharged, baby clothes, and others as appropriate.

CB-PM PAIN MANAGEMENT

OUTCOME: The patient will be aware of the modalities and techniques that are available for pain management during labor and delivery, and after delivery.

STANDARDS:

1. Explain the current understanding of the cause of "labor pains".
2. Review and compare the benefits and risks of "natural" labor (incorporating the use of touch, relaxation, focusing and breathing techniques) with narcotic analgesia during labor, or an epidural, as applicable. Explain that breathing and relaxation techniques may be useful as adjuncts to medications.
3. Explain that it is not always possible to completely relieve pain during labor.

CB-PRO PROCEDURES, OBSTETRICAL

OUTCOME: The patient will verbalize a basic understanding of the procedures utilized during labor, delivery and the immediate postpartum period.

STANDARDS:

1. Explain, in understandable language, the reasons for and procedure for the following as applicable (include simple demonstration of equipment as appropriate).
 - a. Central monitoring at nurses' station
 - b. External fetal monitoring.
 - c. Internal fetal monitoring with scalp electrodes.
 - d. Intrauterine pressure monitoring.
 - e. Induction and/or augmentation of labor, including cervical ripening.
 - f. Rupture of the amniotic membrane.
 - g. Amniotic fluid replacement by infusion.
 - h. Episiotomy and repair of lacerations.
 - i. Forceps and/or vacuum assisted delivery.
 - j. Epidural anesthesia
2. Discuss the possibility of Cesarean section, both emergency and planned. Discuss indications for Cesarean section, preparation, policies regarding labor coach in OR, postanesthesia recovery, postpartum, length of hospitalization, etc. Discuss risks of Cesarean section as well as benefits and alternatives to this procedure. Discuss possible risks of non-treatment.

CB-RO ROLE OF LABOR AND DELIVERY PARTNER/COACH

OUTCOME: The patient and delivery partner/coach will verbalize understanding of the role of the labor and delivery partner/coach and be able to demonstrate the various techniques taught.

STANDARDS:

1. Explain that the role of the partner/coach during the stages of labor and birth is to help the mother focus and practice techniques and to assist in comfort measures.
2. Refer to [PN](#), [PP](#).

CKD-AP ANATOMY AND PHYSIOLOGY

OUTCOME: Patient and family will have a basic understanding of where the kidneys are located in the body and their function

STANDARDS:

1. Explain that there are two kidneys in the body located on either side of the spine and extend a little below the ribs.
2. Explain that the kidneys are bean-shaped organs and is about the size of a fist.
3. Explain that the kidneys receive approximately 10% of the blood that is pumped out of our heart every minute.
4. Explain that the kidneys are responsible for performing various roles in maintaining a balance of fluid and chemicals in the body. They have four basic functions:
 - a. Regulation of body fluid
 - b. Balance of chemicals in the body (potassium, calcium, sodium, phosphorus)
 - c. Removal of waste products from bloodstream/body (urea, creatinine, phosphorus).
 - d. Secretion of three hormones: Renin, which regulates blood pressure. Erythropoietin, which stimulates the bone marrow to produce red blood cells. Calcitrol (1,25 dihydroxyvitamin D3), the active form of vitamin D helps stimulate absorption of calcium by the intestine and bone.

CKD-C COMPLICATIONS**OUTCOME:**

1. Patient and family will understand the complications/symptoms of untreated or progressive kidney disease.
2. The patient/family will understand the complications associated with dialysis treatment. (Please choose from the following standards as they apply to the patient's specific disease process.)

STANDARDS:

1. Explain that CKD is progressive in nature.
2. Explain that anemia is a common consequence of chronic kidney failure due to a decrease in erythropoietin production from the kidneys or there may be a lack of iron in the blood.
3. Explain how uncontrolled hypertension hurts the blood vessels in the kidneys and increases the risk for cardiovascular disease.
4. Explain how malnutrition can result from inadequate caloric and protein intake due to loss of appetite or uremia.
5. Explain how bone disease develops from a consequence of phosphorus retention and calcitriol deficiency leading to secondary hyperparathyroidism.
6. Explain that as the kidney function decreases, functional status (i.e., quality of life) may decrease and well-being may be affected.
7. Explain how CKD increases the risk for heart/cardiovascular disease.
8. Explain that as toxins build up in the blood, patient may experience symptoms of uremia (inability to think clearly, nausea, vomiting, itchiness, loss of appetite, altered smell & taste, etc.).
9. Explain that as the kidney function declines, a patient may experience weight gain from excess fluids, swollen ankles and feet, puffiness around eyes, including high blood pressure.
10. Explain that as the kidney function declines, a patient with diabetes may have changes in diabetes control and need less diabetes medications, to reduce risk for low blood sugar.
11. Explain that even with proper dialysis, patients may experience fluid imbalances; shortness of breath, unusual swelling, dizziness, etc. should prompt medical evaluation.

CKD-DP DISEASE PROCESS

OUTCOME: Patient and family will have an understanding of their specific type of chronic kidney disease (CKD). (Choose from the following standards that apply to this patient's specific chronic kidney disease process.)

STANDARDS:

1. Explain that chronic kidney disease is irreversible and progressive. CKD can have many causes including:
 - a. Diabetic nephropathy
 - b. Hypertension
 - c. Glomerulonephritis
 - d. Infections, urinary tract abnormalities.
2. Explain the basic pathophysiology of the specific type of CKD and its symptoms.

CKD – EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding of hemodialysis and equipment used for home dialysis.

STANDARDS:

1. Explain function of hemodialysis machine and components used in filtering patient's blood.
2. Discuss types and features of medical equipment used for peritoneal dialysis.
3. Discuss proper disposal of used medical supplies.

CKD – LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/ family will strive to make the lifestyle adaptation necessary to deal with and prevent complications of the specific kidney disease and improve overall health.

STANDARDS

1. Discuss that kidney disease is different for everyone. Advice from the doctor may change if the disease continues to progress. Explain that they can participate in their own care and ask questions.
2. Review the lifestyle aspects/changes that the patient has control over – food and exercise, taking medications safely, follow-up appointments, tobacco, alcohol.
3. Explain that the patient should avoid blood draws (venipuncture), IVs and blood pressures on the non-dominant arm to protect blood vessels for potential dialysis access.
4. When discussing renal replacement therapy options, explain that people on dialysis or who have had a kidney transplant can still work. Rehabilitation is preferred.
5. Review the community resources available to assist the patient in making lifestyle changes and make referrals as appropriate.
6. Explain that kidney failure affects not only the patient but, family and friends as a major crisis. It is not uncommon for patients and their families to have feelings of fear, guilt, denial, anger, depression, and frustration but there is help available.
7. Explain that a mental health assessment might be beneficial - to allow patient to grieve through the emotional aspect (loss of kidney function). The patient may need to assess their own traditional beliefs to begin accepting dialysis treatment.

CKD - M MEDICATIONS

OUTCOME: The patient/family will understand the medications prescribed in the management of his/her kidney disease.

STANDARDS:

1. Discuss proper use, benefits, common side effects and common interactions of prescribed medication including drug/drug and drug/food interactions.
2. Explain to the patient/family that the patient's physician(s) should be contacted before starting, stopping or changing any prescription medications, over-the-counter medications or dietary supplements.
3. Explain that the doctor may tell the patient to avoid certain medications like NSAIDs.
4. Explain that phosphate binding medications are necessary for many people with kidney disease. They serve two purposes- increase calcium in bones & help reduce phosphate levels.
5. Explain that the patient's medications may change after starting dialysis (prn).
6. Emphasize the importance of bringing all medications to medical appointments.

CKD - N NUTRITION

OUTCOME: The patient/family will verbalize an understanding of how diet relates to kidney disease.

STANDARDS:

1. Explain that an appropriate dietary regimen is essential in the management and treatment of kidney disease.
2. Discuss that the dietary regimen will change as laboratory values and other indices change in conjunction with disease progression and treatment.
3. All kidney disease patients must meet regularly with a Registered Dietitian for ongoing medical nutrition therapy.

CKD-P PREVENTION**OUTCOME:**

1. The patient/family will understand how to prevent or slow progression of chronic kidney disease (CKD).
2. The patient/family will understand how to prevent complication(s) associated with vascular access placement, i.e., AV fistula, graft, or central line catheter.

STANDARDS:

1. Discuss with patient/family the importance of treating/controlling other medical conditions associated with CKD such as adequate blood glucose control in diabetic patients, high blood pressure control, and control of elevated cholesterol.
2. Screening family members who are at high risk for chronic kidney disease.
3. Emphasize the importance of using aseptic technique with peritoneal catheter care and during exchanges.
4. Emphasize the importance of keeping the central line catheter clean, dry, and avoid touching to prevent infection.
5. Emphasize the importance of assessing vascular access, i.e., feeling for thrill, checking for numbness, bleeding, and redness.

CKD-PRO PROCEDURES

OUTCOME: The patient/family will verbalize understanding of the risks, benefits, and alternatives of the proposed procedure(s) to be performed.

STANDARDS:

1. Explain the specific proposed procedure(s), i.e., biopsy, fistula, graft, central catheter, or peritoneal catheter to be performed, including the risks and benefits.
2. Discuss possible alternative(s) to the proposed procedure(s), i.e., fistula, graft, central catheter, or peritoneal catheter, in the event that the proposed procedure is not recommended.
3. Discuss with patient/family the involvement of required post-operative and maintenance care following the proposed procedure(s).

CKD-TE TESTS

OUTCOME: The patient/family will have a basic understanding of the test(s) to be performed, indications, and its influence on further care.

STANDARDS:

1. Explain the specific test(s) ordered, i.e., blood urea nitrogen, creatinine, phosphorus, calcium, albumin, urinalysis, CBC, etc.
2. Explain the necessity, benefits, and risks of the test(s) to be performed and how it relates to the course of treatment.
3. Explain any necessary preparation for the testing, i.e., fasting.
4. Explain the meaning of the test results and its impact on further treatment.

CKD-TX TREATMENT**OUTCOMES:**

1. The patient/family will have a basic understanding of treatment plan for CKD.
2. The patient/family will have a basic understanding of the various modalities of renal replacement therapy to make an informed decision.

STANDARDS:

1. Discuss the specific treatment plan for CKD including treatment to conserve renal function and eventual need for renal replacement therapy.
2. Emphasize adherence to medications, dietary, and lifestyle changes that may impede the rate of progression of chronic kidney disease.
3. Discuss the treatment plan with patient/family; emphasize the importance of adherence with therapeutic regimen, even if the patient is asymptomatic.
4. Explain each possible renal replacement therapy: (**Refer to [DIA](#)**)
 - a. Hemodialysis
 - i. Hemodialysis is the use of an artificial filtering of blood by a machine, removing metabolic wastes and excess fluids from the body.
 - ii. This procedure is normally initiated three times per week. Each session is usually three to four hours at a hemodialysis center.
 - iii. A fistula, a surgical connection of major blood vessels, is normally placed in the arm prior to the start of dialysis. A temporary placement may be established in other sites of the body such as the neck when an emergent condition arises.
 - b. Peritoneal dialysis
 - i. Peritoneal dialysis involves an artificial filtering of the blood by a bagged solution.

- ii. This form of dialysis removes metabolic wastes and excess fluids from the body. This is done through an exchange system via osmosis to remove water and diffusion for glucose exchange/waste removal.
- iii. This procedure is preformed on a daily basis at home.
- iv. Each session is dependent on the two different types of peritoneal dialysis used.
 - (1) Intermittent Peritoneal Dialysis (IPD). This is normally completed once per day using multiple bags of dialysate, (bags of glucose fluids). A partner is usually needed.
 - (2) Continuous Cycling Peritoneal Dialysis (CCPD). This is normally a nocturnal procedure regulated by an infusion pump administering a set amount of dialysate exchange throughout the night.
 - (3) Continuous Ambulatory Peritoneal Dialysis (CAPD). This procedure is performed four times per day and there is fluid in the abdomen nearly 100% of the time. A partner is not necessary for this procedure.
- c. Kidney transplant
 - i. Kidney transplantation is completed in end stage kidney disease when the glomerular filtration rate drops to 10 mL/min.
 - ii. Persons older then 50 years of age with poor health or history of cancer often can not receive a transplant.
 - iii. Children must receive an evaluation from a pediatric renal transplant team prior to receiving a transplant or being considered as a donor.
 - iv. After a renal transplant, the patient has a functioning donor kidney. Medications and regular medical evaluations will usually be required to prevent rejection.
 - v. It is important for patients to understand that anti-rejection medication must be taken as prescribed through out their life to prevent kidney rejection. Anti-rejection medications may have very unpleasant side effects.
 - vi. Patients with co-morbidities leading to initial kidney failure must be instructed to follow all prescribed regimens to avoid subsequent kidney failure.
 - vii. There is a possibility that a donor kidney may fail or be rejected even under ideal conditions.
- 5. Review with the patient/family the risks and benefits of each renal replacement therapy option and the consequences of refusing treatment.

CPM-DP DISEASE PROCESS

OUTCOMES: The patient/family will understand the pathophysiology of the patient's specific condition.

STANDARDS:

1. Review the causative factors as appropriate to the patient. Assess the level of pain. Emphasize that the goal of treatment is to relieve pain.
2. Review lifestyle factors which may worsen or aggravate the condition.
3. Discuss the patient's specific condition, including anatomy and pathophysiology as appropriate.
4. Discuss that chronic pain is a multifaceted condition. Explain that control of contributing factors may help to control the pain, i.e., dysfunctional sleep patterns, depression or other psychological disorders, other disease states.

CPM-EX EXERCISE

OUTCOMES: The patient will understand the importance of exercise in enhancing physical and psychological well-being.

STANDARDS:

1. Review the different types of exercise including active and passive range of motion and strengthening.
2. Explain the hazards of immobility. Discuss how to prevent contractures, constipation, isolation and loss of self-esteem.
3. Emphasize that physical activity/therapy is an integral part of the patient's daily routine.
4. Emphasize that moderate exercise may increase energy, control weight, improve circulation, enhance sleep, and reduce stress and depression.

CPM-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. Provide positive reinforcement for areas of achievement.
2. Emphasize the importance of follow-up care to prevent complications and adjustments of medication.
3. Encourage active participation in the treatment plan and acceptance of the diagnosis.
4. Explain the procedure for obtaining appointments.

CPM-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

CPM-LA LIFESTYLE ADAPTATIONS

OUTCOMES: The patient/family will understand what lifestyle adaptations are necessary to cope with the patient's specific disorder.

STANDARDS:

1. Explain that the patient has a responsibility to make lifestyle adaptations to assist in controlling pain.
2. Assess the patient/family's level of acceptance of the disorder.
3. Emphasize the importance of rest and avoidance of fatigue.
4. Discuss the use of heat and cold as appropriate.
5. Refer to Social Services, Mental Health, Physical Therapy, Rehabilitative Services and/or community resources as appropriate.
6. Review the areas that may require adaptations: diet, physical activity, sexual activity, and bladder/bowel habits.

CPM–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 side effects, signs of toxicity, and drug/drug or drug/food interactions of medications.
3. Discuss the importance of taking medications as prescribed.
4. Emphasize the importance of taking medications as prescribed. If more medication is needed consult with the medical provider prior to increasing the dose of medication.
5. Discuss non-pharmacologic pain control measures.

CPM–S SAFETY

OUTCOMES: The patient will understand the importance of injury prevention and safety.

STANDARDS:

1. Explain to patient/family the importance of body mechanics to avoid injury.
2. Assist the family in identifying ways to adapt the home to prevent injuries or improve safety (remove throw rugs, install bars in the tub/shower, etc.).
3. Stress importance and proper use of mobility devices (cane, walker, wheel chair, etc.).

CDC-DP DISEASE PROCESS

OUTCOME: The patient and 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 comply 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 verbalize understanding of 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 have an understanding of 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.

CHF-C COMPLICATIONS

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

STANDARDS:

1. Discuss common complications of CHF (pulmonary or peripheral edema, MI, death, inability to perform activities of daily living, etc.).
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-DP DISEASE PROCESS

OUTCOME: The patient/family will have an understanding of 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, etc.
3. Review signs and symptoms of CHF including swelling, fatigue, shortness of breath, weight gain, etc.

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 adherence to treatment regimen and appointment adherence.

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, medication adherence, adhering 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 have an understanding of 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 have an understanding of 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 strict adherence to 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 dietician or other local resources as available.
5. Assist in developing appropriate diet plan to achieve optimal weight and sodium control.

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 (chest pain, nausea, loss of consciousness, jaw/arm pain, SOB, diaphoresis, etc.).

CAD-DP DISEASE PROCESS

OUTCOME: The patient will have an understanding of 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 of 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-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.

CAD-FU FOLLOW-UP

OUTCOME: The patient will verbalize an understanding of 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, complying 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 have an understanding of 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 have an understanding of 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 adherence to the medication regimen.

CAD-N NUTRITION

OUTCOME: The patient/family will have an understanding of 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 have an understanding of 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 verbalize 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 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-TE TESTS

OUTCOME: The patient/family will have an understanding of 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 have an understanding of 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 (angioplasty, coronary stent, coronary artery bypass, etc).
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.

CRN-C COMPLICATIONS

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

STANDARDS:

1. Explain that some possible complications of Crohn's disease are stricture and fistulae formation, hemorrhage, bowel perforation, mechanical intestinal obstruction, and colorectal cancer, etc.
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., blood in the stool, unusual drainage, unusual abdominal pain, change in frequency of stools, fever.

CRN-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of their Crohn's disease.

STANDARDS:

1. Explain that Crohn's disease is a chronic inflammatory disease of the small intestine, usually affecting the terminal ileum at the region just before the ileum joins the colon. The etiology is unknown.
2. Explain that there is a familial tendency toward Crohn's disease and it occurs mostly in those between 15 and 35 years of age.
3. Explain that this condition interferes with the ability of the intestine to transport the contents of the upper intestine through the constricted lumen, causing crampy pains after meals.
4. Explain that chronic diarrhea due to the irritating discharge from the intestine occurs and may be accompanied by bloody stools.
5. Explain that in some patients, the inflamed intestine may perforate and form intra-abdominal and anal abscesses.
6. Explain that this condition is characterized by exacerbations and remissions that may be abrupt or insidious.

CRN-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.

CRN-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the Crohn's disease.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding Crohn's disease.
2. Discuss the content of the patient information literature with the patient/family.

CRN-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. Caution the patient/family against utilizing over-the-counter medications for constipation without consulting his/her provider.

CRN-N NUTRITION

OUTCOME: The patient/family will have an understanding of 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. Instruct the patient/family to abstain from fresh fruits, fresh vegetables and dairy products and eat foods that are low in fats. Provide a list of foods for the patient to avoid, if available.
3. Assist the patient/family in developing appropriate meal plans.
4. Explain to the patient/family that parenteral hyperalimentation may be necessary to maintain nutrition while allowing the bowel to rest.
5. Refer to dietitian as appropriate.

CRN-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.

CRN-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of the plan for pain management.

STANDARDS:

1. Advise the patient/family to strictly follow dietary guidelines to assist in the control of crampy pain after meals.
2. Advise the patient to comply with medication regimen to decrease the inflammation and pain.
3. Instruct the patient in meticulous anal skin care with protective creams to prevent skin breakdown and pain.
4. Advise the patient not to use over the counter pain medications without checking with his/her provider.

CRN-TE TESTS

OUTCOME: The patient/family will have an understanding of the tests to be performed. The patient/family will further understand the risk/benefit ratio of the proposed testing, alternatives to testing and risks of non-testing.

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.
4. Discuss the risk/benefit ratio of testing, alternatives to testing and the risk of non-testing.

CRN-TX TREATMENT

OUTCOME: The patient/family will have an understanding of the appropriate treatment for bowel disease and verbalize a plan to adhere to the treatment regimen. The patient/family will further understand the risk/benefit ratio of the proposed treatment, alternatives to treatment and the risk of non-treatment.

STANDARDS:

1. Discuss the specific treatment plan, which may include the following:
 - a. A diet restricted to no fruits or vegetables, low in fats and free of dairy products.
 - b. Parenteral hyperalimentation to maintain nutrition while allowing the bowel to rest.
 - c. Corticosteroids, salicylates, and/or other anti-inflammatory agents to decrease inflammation.
 - d. Medications to control diarrhea.
 - e. Rest.
 - f. Surgery to correct hemorrhage, fistulas, bowel perforation or intestinal obstruction.
2. Discuss the risk/benefit ratio of the proposed treatment, alternatives to treatment and the risk of non-treatment.

CRP-C COMPLICATIONS

OUTCOME: The patient/family will have an understanding of 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, etc.).

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-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 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.

CF-C COMPLICATIONS

OUTCOME: The patient/family will understand common and important complications of cystic fibrosis.

STANDARDS:

1. Discuss pulmonary complications of cystic fibrosis as appropriate.
2. Discuss that cystic fibrosis may affect any part of the respiratory mucosa.
3. Discuss that exocrine pancreatic failure may cause fat malabsorption and lead to growth delay or failure.
4. Discuss that endocrine pancreatic failure may lead to glucose intolerance or insufficient insulin secretion.
5. Discuss that cirrhosis may result from severe forms of cystic fibrosis.
6. Discuss that persons with cystic fibrosis may be sterile as a result of the disease process.

CF-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the disease process of Cystic Fibrosis.

STANDARDS:

1. Explain that cystic fibrosis is a form of genetic disorder known as an autosomal recessive. This means that to have the disease, a person must inherit a gene from both parents.
2. Explain that cystic fibrosis is a chronic and progressive disease that causes mucus to become thick, dry and sticky. This results in end organ problems especially in the lungs, pancreas, and spermatid tubules.
3. Explain that the environment, diet, exercise, or other lifestyle behaviors do not cause cystic fibrosis. The disease is not contagious and cannot be passed from one person to another except through inheritance.
4. Explain that cystic fibrosis is usually diagnosed during childhood.
5. Explain that the course of cystic fibrosis varies. Some babies show signs immediately (meconium ileus or severe respiratory problems/infections) while others may not develop symptoms for years. Some people with cystic fibrosis have a shortened life expectancy.
6. Explain the symptoms of cystic fibrosis.
7. Explain that most people with cystic fibrosis have problems with their digestive system and/or lungs. Many people have growth deficiency.
8. Explain that there is no cure for the disease but those with cystic fibrosis can live productive lives.

CF-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding of any medical equipment utilized by this patient.

STANDARDS:

1. Discuss indications for and benefits of prescribed medical equipment.
2. Discuss types and features of medical equipment as appropriate.
3. Discuss and/or demonstrate proper use and care of 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 O₂ use of gloves, electrical cord safety, and disposal of sharps.

CF-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. Emphasize that appointments should be kept.
3. Discuss the procedure for obtaining follow-up appointments.
4. Encourage genetic counseling prior to starting a family.

CF-L PATIENT LITERATURE INFORMATION

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

STANDARDS:

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

CF-N NUTRITION

OUTCOME: The patient/family will have an understanding of the special nutritional requirements of some patients with cystic fibrosis.

STANDARDS:

1. Discuss the need for adequate calories and protein for optimal growth and development and resistance to infection.
2. Discuss as appropriate the need for pancreatic enzyme supplementation.
3. Discuss supplementation of water miscible sources of fat soluble vitamins and iron as needed.
4. Discuss supplementation of medium chain triglyceride oils as needed.
5. Discuss the need for liberal water intake, or if extra calories are needed, calorie containing fluids. Discourage intake of dehydrating beverages such as soft drinks or other caffeinated beverages.
6. Discuss that some patients with cystic fibrosis will have the need for salt supplementation.
7. Explain that if the patient is lactose intolerant, sources of calcium other than milk may be necessary. Refer to a registered dietician or physician for specific information as appropriate.
8. Discuss other aspects of nutrition support as appropriate.

CF-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” and 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 the 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 patient with cystic fibrosis 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 with cystic fibrosis 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.

CF-TE TESTS

OUTCOME: The patient/family will have an understanding of the tests to be performed.

STANDARDS:

1. Explain that the most common diagnostic test for cystic fibrosis is a sweat chloride test. Explain that this is a non-painful procedure.
2. Discuss the possible need for genetic testing of the patient and the impact on diagnosis and/or prognosis. Discuss the need for genetic testing for family members as well as the patient’s present and future sexual partners and the impact on future progeny.
3. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.

CF-TO TOBACCO (SMOKING)

OUTCOME: The patient and/or family will have an understanding of the dangers of smoking in the patient with cystic fibrosis and develop a plan to cut back or stop smoking.

STANDARDS:

1. Explain the increased risk of illness in the patient with cystic fibrosis 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, hospitalization or premature death.
3. Refer to [TO](#).

CF-TX TREATMENT

OUTCOME: The patient/family will understand and participate in the formulation of a treatment plan.

STANDARDS:

1. Explain that management varies from person to person depending on the organ systems which are involved.
2. Discuss the current treatment plan for this patient.

DEH-C COMPLICATIONS

OUTCOME: The patient/family will have an understanding of 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 have an understanding of 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 - weight loss; thirst; poor skin turgor; dry skin, dry mucous membranes and tongue; soft and sunken eyeballs; sunken fontanel in infants; apprehension and restlessness or listlessness; concentrated urine, low-grade fever; lack of tears, headache, irritability, etc.
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-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 adherence 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 have an understanding of 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.

DC-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand that different components make up the tooth structure. The patient/family will further understand that the properties of the various components affect the susceptibility for decay.

STANDARDS:

1. Explain that enamel is a protective covering for the tooth. Discuss that the portion of the tooth that is normally seen in the mouth (crown) is covered with enamel.
2. Explain that the root of the tooth is not covered with enamel. The root of the tooth is made of dentin. Explain that dentin is a softer, more easily decayed substance.
3. Explain that the living portion of the tooth (pulp) is a sensitive structure containing the nerve and blood vessels. Decay into this portion of the tooth may cause severe pain and will kill the tooth.

DC-C COMPLICATIONS

OUTCOME: The patient/family will understand some complications/consequences of treated or untreated dental caries.

STANDARDS:

1. Explain that, by necessity, when dental caries are treated, a portion of the healthy tooth structure must also be removed. This results in a weakening of the tooth.
2. Explain that occasionally when dental caries are treated, inflammation of the pulp may occur. This insult may be reversible and result in temporary soreness of the tooth, or may be irreversible and result in infection and/or death of the tooth.
3. Explain that occasionally dental caries may result in abscess of the tooth, which may extend into a sinus or other adjacent tissues.
4. Explain that some dental caries may involve so much of the tooth structure that root canal or removal of the tooth may be necessary.
5. Explain that early tooth loss in children may cause abnormal eruption of permanent teeth. Further explain that early tooth loss of permanent teeth may result in loosening of other teeth and further tooth loss unless restorative measures are taken.

DC-DP DISEASE PROCESS

OUTCOME: The patient/family will be able to explain what dental caries are and summarize some causes as appropriate to this patient.

STANDARDS:

1. Explain that natural bacteria live in the mouth. Some bacteria are healthy and are protective. Explain that a sticky film called plaque forms on teeth and that bacteria live in the plaque.
2. Explain that some bacteria in the presence of carbohydrates will produce acids that attack the tooth structure. The acids dissolve and demineralize the tooth weakening the tooth structure. Progressive acid attacks on the tooth surface may lead to decay or dental caries.
3. Explain the various factors which may predispose a person to dental caries:
 - a. Poor oral hygiene
 - b. High carbohydrate diet, especially frequent consumption
 - c. Children whose parents have active tooth decay
 - d. Lack of fluoride
 - e. Gingival recession
 - f. Persons having undergone radiation therapy
 - g. Genetic predisposition

DC-FU FOLLOW-UP

OUTCOME: The patient/family will verbalize understanding of the importance of regular dental follow-up.

STANDARDS:

1. Explain the current recommendation for regular dental examination and professional tooth cleaning.
2. Emphasize the importance of a dental visit if any problems occur between routine dental visits.

DC-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about dental caries, their treatment and/or the oral care necessary after treatment.

STANDARDS:

1. Provide patient/family with written patient information literature on dental caries, treatment and/or the oral care necessary after treatment.
2. Discuss the content of the patient information literature with the patient/family.

DC-N NUTRITION

OUTCOME: The patient/family will understand the importance of a balanced diet, low in carbohydrates, especially simple sugars, and with adequate calcium and fluoride.

STANDARDS:

1. Discuss the relationship between a diet high in carbohydrates, especially simple sugars, to the development of dental caries. Give examples of foods high in simple sugars, i.e., crackers, potato chips, candy, pre-sweetened cereals.
2. Discuss the importance of calcium and fluoride intake as it relates to tooth development/mineralization.
3. Refer to a dietician as appropriate.

DC-P PREVENTION

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

STANDARDS:

1. Explain that early entry into dental care (infancy and prenatal) is important in the prevention of dental caries.
2. Explain that an important factor in the prevention of cavities is the removal of plaque by brushing the teeth and flossing between them daily. Discuss and/or demonstrate the current recommendations and appropriate method for brushing and flossing.
3. Explain that the frequency of carbohydrate consumption increases the rate of acid attacks, thereby increasing the risk of dental decay. **Refer to [DC-N](#).**
4. Explain that pathogenic oral bacteria may be transmitted from one person to another; therefore, it is especially important that families with small children (ages 6 months to 8 years) control active tooth decay in all family members.
5. Explain that the use of fluoride strengthens teeth and may rebuild the early damage caused by bacteria/acid attacks. The most common source of fluoride is drinking water. It is also available in toothpastes and rinses, varnishes or fluoride drops/tablets. Consult with a dentist/physician to determine if the drinking water contains adequate fluoride and if supplementation is needed. Explain that the use of topical fluoride is important in the prevention of decay in persons exposed to radiation therapy, as applicable.
6. As appropriate, discuss sealants as an intervention to prevent dental caries.
7. Explain that the recession of gingival tissue (gums) exposes the softer dentin portion of the tooth (root). This portion of the tooth does not have an enamel covering, therefore, it is more susceptible to decay. Gingival recession may have a variety of causes:
 - a. Natural aging process
 - b. Loss of attached tissue associated with periodontal disease **Refer to [PD](#).**
 - c. Improper brushing methods
 - d. Genetic predisposition (frenulum/frenum attachment)

DC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of 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 Tylenol, NSAIDS, desensitizers, and/or narcotics may be helpful in pain management as appropriate.
3. Explain that antibiotics may be helpful in pain relief in the case of abscess.
4. Explain non-pharmacologic measures that may be helpful with pain control, i.e., avoid hot and cold foods.
5. Explain that dental anxiety may be controlled or relieved by the use of anxiolytics or antihistamines as appropriate.
6. Explain that local anesthetics and/or nitrous oxide may be used to control pain during dental procedures.

DC-TE TESTS

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

STANDARDS:

1. Discuss the test(s) to be performed, i.e., x-ray, pulp vitality.
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.

DC-TX TREATMENT

OUTCOME: The patient will understand the necessary treatment (filling, root canal, extraction) and the proper oral care after treatment.

STANDARDS:

1. Explain the basic procedure to be used (filling, root canal, extraction) and the indication, common complications and alternatives as well as the risks of non-treatment.
2. Review the specific elements of oral care after treatment. **Refer to [DC-P](#).**
3. Discuss the indications for returning to the provider, i.e., bleeding, persistent or increasing pain and fever.

DM-C COMPLICATIONS

OUTCOME: The patient/family will understand common or serious complications of uncontrolled blood sugar.

STANDARDS:

1. Emphasize that the end-organ damage (kidney failure, blindness, heart attack, impotence, limb amputations, etc.) results directly from high blood sugar and that the goal of management is to keep blood sugar as near to normal as possible.
2. Emphasize that good control of blood sugar can dramatically reduce the risk of complications and end-organ damage.
3. State that Type 2 DM is a chronic disease that needs to be monitored for complications. Routine examinations are essential.
4. Discuss common complications of uncontrolled high blood sugar (blindness, impotence, increased yeast infections, increased urinary tract infections, kidney failure, loss of limbs, heart attack, stroke, early death, etc.).
5. Explain that patients with Type 2 DM are at high risk for infectious diseases. Review the current recommendations for immunizations and refer for immunization as appropriate. **Refer to [IM](#).**
6. Explain that patients with Type 2 DM are at high risk for visual loss. Review the current recommendations for eye examinations and refer to appropriate health-care providers. **Refer to [ODM](#).**
7. Explain that uncontrolled blood sugar can result in small-vessel damage in the heart which leads to heart attacks and cannot usually be treated. Explain that Type 2 DM also worsens atherosclerotic disease which can also lead to heart attacks and strokes. **Refer to [CVA](#), [CAD](#), and [PVD](#).**

DM-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of Type 2 DM.

STANDARDS:

1. Briefly describe the pathophysiology of Type 2 DM, including the concept of insulin resistance.
2. Emphasize that the end-organ damage (kidney failure, blindness, heart attack, impotence, limb amputations, etc.) results directly from high blood sugar and that the goal of management is to keep blood sugar as near to normal as possible.
3. Describe risk factors for development and progression of Type 2 DM (family history, obesity, high intake of simple carbohydrates, sedentary lifestyle, etc.).
4. Describe feelings/symptoms which the patient may experience when blood sugar is high (increased thirst, increased urination, lethargy, headache, blurry vision, impaired concentration, etc.).
5. Emphasize that Type 2 DM is a chronic, controllable condition which requires permanent lifestyle alterations and continuous attention and medical care. **Refer to [DM-LA](#).**

DM-EQ EQUIPMENT

OUTCOME: The patient/family will understand the home management and self-care activities necessary to control blood sugar and make a plan to integrate these activities into daily life.

STANDARDS:

1. Discuss the specific components of this patient's home glucose monitoring and/or home blood pressure monitoring and/or home ketone monitoring and/or home insulin pumps.
2. Demonstrate and receive return demonstration of home glucose monitoring and/or the use of other home equipment.
3. Explain that home glucose monitoring (when prescribed) is a tool to assist the patient in home management of blood sugar.
4. Discuss the importance of logging home glucose readings and insulin administration and emphasize the importance of bringing the record to all medical appointments.
5. Emphasize the importance of home blood pressure monitoring as appropriate.

DM-EX EXERCISE

OUTCOME: The patient/family will understand the relationship of physical activity in achieving and maintaining good blood sugar control and will make a plan to increase regular activity by and agreed-upon amount.

STANDARDS:

1. Explain that regular aerobic exercise will reduce the body's resistance to insulin.
2. Explain that the goal is at least 20-30 minutes of aerobic exercise (such as vigorous walking) at least 5 times per week. 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.

DM-FTC FOOT CARE AND EXAMINATIONS

OUTCOME: The patient/family will understand the risks of skin breakdown, ulcers, and lower extremity amputation associated with Type 2 DM and develop a plan for blood sugar control and regular foot care to prevent these complications.

STANDARDS:

1. Emphasize that even a minor injury to the foot can result in amputation. Stress that wounds do not heal properly if blood sugar is elevated.
2. Demonstrate the proper technique for a daily home foot check by patient or support person.
3. Discuss “dos and don'ts” of diabetic foot care (don't go barefoot, wear appropriate footwear, don't trim you own nails, etc.).
4. Discuss the relationship between peripheral vascular disease, neuropathy, and high blood sugar. Explain that the progression to amputation is typical without early and appropriate intervention. **Refer to [PVD](#).**
5. Emphasize the importance of footwear which is properly fitted for patient with diabetes. Refer for professional evaluation and fitting as appropriate.
6. Remind the patient to remove shoes for each clinic visit.
7. Emphasize the importance of a regularly scheduled detailed foot exam by a trained health care provider.

DM-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of early intervention to prevent complications.
2. Explain that since blood sugar control is critical, regular medical appointments are necessary to adjust treatment plans and prevent complications.
3. Explain that the home glucose monitoring log is an essential part of formulating the treatment plan and must be brought to every appointment.
4. Explain that since Type 2 DM is a chronic condition which affects the entire body, total care is essential. Emphasize the importance of keeping appointments with all health care providers (dental, eye care, foot care, laboratory, etc.).
5. Discuss the procedure for making appointments.

DM-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management and self-care activities necessary to control blood sugar and make a plan to integrate these activities into daily life.

STANDARDS:

1. Discuss the specific components of this patient's home management (nutrition, exercise, home glucose monitoring, self-administration of insulin, taking medications, etc.).
2. Demonstrate and receive return demonstration of home glucose monitoring and/or insulin administration as appropriate.
3. Describe proper storage, care and disposal of medicine and supplies.
4. Explain that home glucose monitoring (when prescribed) is a tool to assist the patient in home management of blood sugar.
5. Discuss the importance of logging home glucose readings and insulin administration and emphasize the importance of bringing the record to all medical appointments.
6. Emphasize the importance of daily foot checks and appropriate foot care. **Refer to [DM-FTC](#).**
7. Emphasize the importance of good personal and oral hygiene. **Refer to [WL-HY](#).**
8. Emphasize the importance of nutritional management. Refer to dietician or other local resources as appropriate.

DM-KID KIDNEY DISEASE

OUTCOME: The patient/family will understand the risks of kidney damage and end-stage renal disease resulting in dialysis associated with Type 2 DM and develop a plan for blood sugar control and regular medical examinations to prevent these complications.

STANDARDS:

1. Emphasize that high blood sugar results in damage to the kidneys. This may result in renal failure requiring long term dialysis or kidney transplant. Once kidney damage occurs it cannot be reversed.
2. Emphasize the need for regular urine analysis and blood chemistry screening.
3. Emphasize that high blood pressure worsens diabetic kidney disease. Reinforce the importance of regular blood pressure screening and taking antihypertensive medications as prescribed. **Refer to [HTN](#).**

DM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about Type 2 DM.

STANDARDS:

1. Provide the patient/family with written patient information on Type 2 DM.
2. Discuss the content of the patient information with the patient/family.

DM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand that the most important component in control of high blood sugar is the patient's lifestyle adaptations and will develop a plan to achieve optimal blood sugar control.

STANDARDS:

1. Emphasize that diet and exercise are the critical components of blood sugar control and medical therapies can at best supplement diet and exercise.
2. Emphasize that the end-organ damage (kidney failure, blindness, heart attack, impotence, limb amputations, etc.) results directly from high blood sugar and that the goal of management is to keep blood sugar as near to normal as possible.
3. Explain that the longer the blood sugar is elevated, the greater the damage will be.
4. State the reasons for blood glucose monitoring – to keep track of the level of blood sugar and permit rapid changes necessary to keep sugar under control.

DM-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication regimen.

STANDARDS:

1. Explain that diet and exercise are the key components of control of Type 2 DM and that medication(s) may be prescribed as a supplement to diet and exercise.
2. Describe the proper use, benefits, and common or important side effects of the patient's medication(s). State the name, dose, and time to take pills and/or insulin.
3. For patients on insulin, demonstrate steps in insulin administration. Describe proper storage, care and disposal of medicine and supplies.
4. Reinforce the need to take insulin and other medications when sick and during other times of stress.
5. Emphasize the importance of strict adherence to the medication regimen. Explain that many medications for Type 2 DM do not exert an immediate effect and must be used regularly to be effective.
6. Briefly explain the mechanism of action of the patient's medications as appropriate.
7. Discuss any significant drug/drug or food/drug interactions, including interaction with alcohol.
8. Discuss the signs, symptoms and appropriate actions for hypoglycemia.

DM-N NUTRITION

OUTCOME: The patient/family will understand the importance of nutritional management in the control of blood sugar and develop a plan to meet nutritional goals.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and responsible eating.
2. Review the food pyramid and its role in meal planning. Refer to dietician or 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 (broiling or baking is preferred over frying, avoid gravies and sauces, rinsing or blotting excess grease, etc.).
5. Emphasize the importance of 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 complex carbohydrates and low-fat proteins are preferred and that sugars and fats should be limited.

DM-P PREVENTION

OUTCOME: The patient/family will understand major risk factors for development of Type 2 DM and will develop a plan for risk reduction.

STANDARDS:

1. Discuss the role of obesity in the development of Type 2 DM.
2. Emphasize that to maintain health and prevent diabetes, extra commitment is necessary for people with a family and/or gestational history of Type 2 DM.
3. Explain that following the food guide pyramid and maintaining adequate activity levels will reduce the risk of getting Type 2 DM.
4. Explain that many people have Type 2 DM for as much as 5-7 years before diagnosis, and that end-organ damage is occurring during that time. Emphasize the importance of regular screening. Discuss current recommendations for screening.
5. Explain that the child of a mother who had high blood sugar during pregnancy is at greatly increased risk for development of Type 2 DM. Emphasize that family planning, pre-conception screening, and early prenatal care can significantly reduce this risk.

DM-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that lower extremity pain may be significant for complications associated with neuropathy which needs to be discussed with the medical provider.
2. Explain that the use of over the counter medications for chronic pain management needs to be assessed by the medical provider to minimize risk to kidney function.
3. Explain that all chest pain must be evaluated by the medical provider to rule out the possibility of myocardial infarction.

DM-WC WOUND CARE

OUTCOME: The patient/family will have an understanding of 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; decreased infection rate, improved healing, etc.
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.

DIA-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient will have a basic understanding of where the kidneys are and their overall function.

STANDARDS:

1. Explain that the normal human body has two kidneys located on either side of the spine just slightly below the ribcage. Each kidney weighs about a quarter of a pound and is the size of a fist. The shape is similar to that of a kidney bean.
2. Discuss that the kidneys help the body maintain fluid levels and assist in regulating blood pressure. In addition, a variety of other chemicals are produced and released by the kidneys so that a balance is always maintained.
3. Review the four major functions of the kidneys, elimination of waste products through an internal blood filtering system, regulation of blood formation and red blood cell production, regulation of blood pressure, and control of the body's chemical and fluid balance.

DIA-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications associated with dialysis and with the decision not to have dialysis.

STANDARDS:

1. Explain that infections are common in dialysis patients and that the patient/family should report all elevations in body temperature to the dialysis staff. Infection, particularly at the site may require immediate hospitalization for IV antibiotic therapy.
2. Explain that deviations from prescribed dietary and fluid restrictions may result in acute metabolic problems, which must be addressed by the dialysis unit.
3. Explain that even with proper dialysis, patients may experience fluid imbalances and that all shortness of breath, unusual swelling, dizziness, etc. should prompt immediate medical evaluation.

DIA-DP**DISEASE PROCESS**

OUTCOME: The patient/family will verbalize understanding of the causes associated with his/her end stage renal disease.

STANDARDS:

1. Explain that End Stage Renal Disease usually results from long term or prolonged medical conditions such as hypertension or diabetes.
2. Chronic kidney failure may also be the result of heredity such as polycystic disease.
3. At present there is no known cure for chronic kidney disease, however dialysis or transplantation are treatment options.

DIA-EQ**EQUIPMENT**

OUTCOME: The patient/family/caregiver will understand the purpose, use, and care associated with the patient's prescribed dialysis regimen.

STANDARDS:

1. Discuss the indications for and benefits of prescribed medical equipment.
2. Discuss and/or demonstrate proper use and care of medical equipment; participate in return demonstration by patient/family/caregiver as appropriate.
3. Discuss signs of equipment malfunction and proper action in case of malfunction.
4. Emphasize the safe use of equipment, including infection control measures. Explain that equipment tubing is designed for a single use.
5. Discuss proper disposal of associated medical supplies.

DIA-FU**FOLLOW-UP**

OUTCOME: The patient/family/caregiver will understand the importance of adherence to the treatment regimen and appropriate follow-up and coordination with all health care providers.

STANDARDS:

1. Discuss the individual's responsibility in the management of end stage renal disease including the responsibility to keep all health care providers informed of changes to the treatment plan.
2. Review the treatment plan with the patient/family/caregiver, emphasizing the importance of follow-up care.
3. Discuss the procedure for obtaining follow-up appointments and the procedure for obtaining emergent care appointments.

DIA-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family/caregiver will receive written information regarding the specific type of dialysis the patient is currently receiving, i.e., hemodialysis or peritoneal dialysis.

STANDARDS:

1. Provide the patient/family/caregiver with written patient information literature on specific mode of dialysis.
2. Discuss the content of patient information literature with the patient/family/caregiver.

DIA-M MEDICATION

OUTCOME: The patient/family/caregiver will understand the medications used in the management of the patient's end stage renal disease.

STANDARDS:

1. Explain the medications to be used by 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.
2. Discuss with patient/family/caregiver the need to review all over the counter medications and herbal products prior to use with the dialysis unit pharmacy staff.
3. Discuss medications which may be used during dialysis and the common or important complications which may result.
4. Explain that the patient's medications may change after starting dialysis. Emphasize the importance of bringing all medications to medical appointments.

DIA-N NUTRITION

OUTCOME: The patient/family will verbalize an understanding of the specific prescribed dietary regimen as it relates to their ongoing dialysis.

STANDARDS:

1. Each diet is individualized, however typical dietary restrictions may include calories, fluids, protein, sodium, potassium, calcium and phosphorus.
2. Refer to a Registered Dietician as appropriate.

DIA-PRO PROCEDURES

OUTCOME: The patient/family will verbalize 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).

SUP-C COMPLICATIONS

OUTCOME: Patient and/or family will understand that excessive intake of vitamins and/or minerals through supplements or functional foods can cause adverse effects up to and including death.

STANDARDS:

1. Explain that some vitamin and/or mineral supplements may interfere with medications. Refer the patient to their physician or pharmacist for more specific information. Stress the importance of consulting a physician, registered dietician, and pharmacist before starting any new supplement.
2. Explain that megadoses of vitamins, minerals, or other supplements may have toxic effects.
3. Discuss common and important signs/symptoms of toxicity as it relates to the patient's supplement regimen.
4. Refer to registered dietician, physician, and pharmacist for specific recommendation.

SUP-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 supplementation plan and keeping follow-up appointments.
2. Discuss the procedure for making appointments.
3. Discuss any necessary preparation for lab test(s).

SUP-I SUPPLEMENT INFORMATION

OUTCOME: Patient and family will understand the indication for supplements including the specific disease process most influenced with the prescribed supplement. Side effects and or negative outcomes will be reviewed in regard to over supplementation.

STANDARDS:

1. Explain the indication for supplementation. As appropriate, discuss supplements which may be appropriate for this patient's disease state, condition, or medication regimen and any supplements which may be contraindicated in this disease state, condition, or medication regimen.
2. Explain the importance of vitamins, minerals and other supplements in the normal functioning of the body.
3. Vitamins are organic compounds, 13 vitamins have been discovered, four of these vitamins are fat soluble and nine are water soluble.
4. Minerals are inorganic compounds because they do not contain carbon structures. There are 22 essential minerals that are needed in the diet.
5. Macrominerals which are needed in large amounts include the following: calcium, phosphorus, magnesium, potassium, sodium, chloride, and sulfur.
6. Trace minerals include but are not limited to the following: iron, copper, selenium, fluoride, iodine, chromium, zinc, manganese, molybdenum, and cobalt
7. Food fortification and functional foods play a very important role in determining the type and supplementation that a patient will receive.

SUP-SCH SCHEDULE

OUTCOME: The patient and family will understand the importance of following the prescribed timing of supplements in regard to other foods and medications.

STANDARDS:

1. Explain that the use of all vitamin/mineral or other type of supplements should be used only under the advice of a registered dietician and a physician.
2. Explain that some supplements may require specific timing when taking other medications and /or supplements, i.e., calcium is better absorbed with a meal but should not usually be taken at the same time as iron supplements.
3. Review schedule with patient and or family.

DCH-EQ EQUIPMENT

OUTCOME: The patient/family will verbalize understanding and demonstrate (when appropriate) proper use and care of home medical equipment provided at hospital discharge.

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 O₂, use of gloves, electrical cord safety, disposal of sharps).
6. Discuss proper disposal of associated medical supplies.

DCH-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care following hospitalization.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize the importance of keeping appointments.

DCH-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of their disease processes following hospital discharge 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 complications, fewer falls/injuries, etc.
3. Explain the use and care of any necessary home medical equipment.

DCH-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information regarding their discharge plans including medical therapies, follow up appointments, and contact information.

STANDARDS:

1. Provide patient/family with written patient information regarding their discharge plans including:
 - a. Medical therapies prescribed
 - b. Follow up appointments
 - c. Follow up lab work
 - d. Assessments required
 - e. Cautions regarding the discharge plans
 - f. Contact information
2. Discuss the discharge plan with the patient/family.

DCH-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 following hospital discharge.

STANDARDS:

1. Review lifestyle aspects/changes that the patient has control over - nutrition, exercise, safety, and injury prevention, avoidance of high risk behaviors, and participation in the 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.

DCH-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. Discuss the importance of following the medical regimen.
3. Discuss the importance of informing your providers and pharmacists of any allergies or adverse medication reactions that you may have experienced.
4. Discuss the importance of being able to identify any discharge medications.
5. Discuss the importance of being able to take the appropriate amount of medication. Ensure dosage forms can be obtained (i.e., breaking tablets in half or using a pill cutter) and that appropriate measuring devices (oral syringes, droppers) are provided and instruction on their use given.

DCH-N NUTRITION

OUTCOME: The patient will verbalize understanding of the need for balanced nutrition and plan for the implementation of dietary modification following hospital discharge if needed.

STANDARDS:

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

DCH-POC PLAN OF CARE

OUTCOME: The patient/family will have a basic understanding of the discharge plan for care, including the plans for pain management.

STANDARDS:

1. Explain the basic plan of care for the patient, including the following:
 - a. Plan for continued home treatment
 - b. Anticipated assessments
 - c. Tests to be performed, including laboratory tests, x-rays, and others
 - d. Therapy to be provided (medication, physical therapy, dressing changes, etc.)
 - e. Advance directives
 - f. Plan for pain management
 - g. Nutrition and dietary plan including restrictions if any
 - h. Follow-up plans

DCH-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 and alternatives for the proposed procedure(s) as well as the risk of not undergoing the procedure.
2. Explain the process and what to expect after the procedure.
3. Discuss pain management as appropriate.
4. Emphasize post-procedure management and follow-up.
5. Discuss procedure findings and implications as appropriate.

DCH-REF REFERRAL

OUTCOME: The patient/family will understand the referral process and financial responsibilities.

STANDARDS:

1. Choose from the following standards as appropriate.
 - a. Emphasize that referrals to outside providers by Indian Health Service primary providers typically will be processed by Contract Health Services.
 - b. Explain the procedure for the referral to the private sector is usually based on a priority system and/or waiting list.
 - c. Explain that coverage by insurance companies and Medicare/Medicaid packages will be utilized prior to utilizing contract health service funds in most cases. The Indian Health Service is a payer of last resort.
 - d. Discuss the rules/regulations of Contract Health Services.
 - e. Refer as appropriate to community resources for Medicaid/Medicare enrollment, i.e., Benefits Coordinator.
 - f. Discuss the importance of follow-up care and the requirement to notify contract health services of any future appointments and procedures by the private sector. **Referrals are for one visit only** (unless otherwise specified.) Future and/or additional referrals must be approved prior to the appointment.

DCH-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. Discuss the patient's responsibility to follow the agreed upon plan of care and to keep follow-up appointments.
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/psycho social services that may be available as appropriate.

DCH-S SAFETY

OUTCOME: The patient/family will have an understanding of the necessary precautions to prevent injury following hospital discharge.

STANDARDS:

1. Discuss the mutually agreed upon plan of care for safety based on the patient-specific risk assessment.
2. Emphasize safe use of equipment. **Refer to [DCH-EQ](#).**

DCH-TE TESTING

OUTCOME: The patient/family will have an understanding of the test(s) to be performed at the time of or following hospital discharge including indications and its impact on further care.

STANDARDS:

1. Explain the test(s) ordered.
2. Explain the necessity, benefits, and risks of the test to be performed.
3. Explain the testing process to help the patient understand what he/she might experience during the test.
4. Explain the meaning of the test results.

DCH-TX TREATMENT

OUTCOME: The patient/family will have an understanding of 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, cultural practices, pharmacologic, and psycho social aspects of the treatment plan.
3. Discuss the importance of participating in the treatment plan, including scheduled follow-up.
4. Refer to community resources as appropriate.

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 have an understanding of 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 have an understanding of 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 have an understanding of 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 have an understanding of the prescribed treatment for diverticulitis/diverticulosis and verbalize a plan to adhere to 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, such as straining during defecation, lifting, coughing, etc.
3. Discourage smoking, as it irritates the intestinal mucosa.

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: Patient and family will have an understanding of 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-TX TREATMENT

OUTCOME: The patient and 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.

LIP-C COMPLICATIONS

OUTCOME: The patient will have an understanding of the complications of uncontrolled dyslipidemia.

STANDARDS:

1. Review the disease process of atherosclerosis/thrombosis, and how high cholesterol is involved in this process and its involvement in cerebrovascular disease (stroke), cardiovascular disease (heart attack), and peripheral vascular disease.
2. Explain that heart attacks may result due to blocked arteries in the heart.
3. Explain that strokes may result due to blocked arteries in the neck or brain.
4. Explain that leg pain and loss of use of legs may result due to blocked arteries in the legs.

LIP-DP DISEASE PROCESS

OUTCOME: The patient will have an understanding of what causes their dyslipidemia.

STANDARDS:

1. Review the causative factors of dyslipidemia (genetic, DM, thyroid disease, liver disease, kidney disease, drugs, etc.) as appropriate to the patient.
2. Review lifestyle factors which may worsen dyslipidemia (obesity, high saturated fat/carbohydrate intake, lack of regular exercise, tobacco use, alcohol intake).
3. Review factors other than dyslipidemias which predispose toward development of atherosclerotic disease (DM, HTN, low HDL, tobacco use, age, or family history of premature heart disease). Emphasize that dyslipidemias in combination with other risk factors greatly increase the risk of other vascular diseases including heart attacks and strokes.

LIP-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 prior to starting/changing any exercise program.

LIP-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of follow-up and will develop a plan to manage their dyslipidemia and to make and keep follow-up appointments.

STANDARDS:

1. Emphasize that the treatment plan and adherence with it are the responsibility of the patient.
2. Encourage the patient to get a fasting lipid profile on a regular schedule, keep appointments, and comply with the therapeutic plan.

LIP-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

LIP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will have an understanding of the lifestyle adaptations necessary to maintain control of dyslipidemia and develop a realistic plan to accomplish this.

STANDARDS:

1. Discuss the importance of regular exercise, weight control, and a reduced fat diet in the control of dyslipidemia.
2. Explain that regular aerobic exercise lowers lipid levels and recommend that the patient should start slow and work up to an appropriate exercise level that is recommended by the health care provider.
3. Discuss the importance of cessation of tobacco use in the control of dyslipidemia.
4. Assist the patient to formulate a therapeutic plan which includes stress reduction, diet, exercise, and medications, as indicated.
5. Review the nationally accepted, current lipid reduction goals and assist the patient to establish a personal goal for lipid control.

LIP-M MEDICATIONS

OUTCOME: The patient will have an understanding of the importance of their prescribed medications.

STANDARDS:

1. Briefly review the different classes of lipid lowering drugs.
2. Review the proper use, benefits, and common side effects of these medications.
3. Review the clinical effects expected with these medications.
4. Review medications which adversely affect lipids as appropriate.

LIP-N NUTRITION

OUTCOME: The patient will have an understanding of the interaction between diet and lipid levels and formulate a healthy nutrition plan.

STANDARDS:

1. Explain the basics of the Step I AHA diet for all patients with dyslipidemia. Refer to dietitian or other local resources as available.
2. Explain the importance of carbohydrates (including alcohol) and their relationship to elevated triglycerides.
3. Discuss the importance of decreasing total dietary fat intake and substituting monounsaturated fats for other dietary fats.

LIP-P PREVENTION

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

STANDARDS:

1. Explain that consuming a diet low in fat and cholesterol, controlling weight, and exercising may help prevent dyslipidemia.

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, etc.

DYS-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of adherence to 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 medication adherence.

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 verbalize and understand the type of medication being used, the prescribed dosage and administration of the medication and will verbalize an understanding of 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 strict adherence to the medication regimen and monitoring schedule.
3. Emphasize the importance of possible drug interactions with foods, drugs and over the counter medications.

DYS-TE TESTS

OUTCOME: The patient will have an understanding of the test to be performed and the reasons for the testing.

STANDARDS:

1. Explain the test(s) ordered (ECG, echo, treadmill, electrophysiological mapping, etc.).
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 strict adherence to the medication regimen.
3. Explain other treatment options as appropriate (synchronized cardioversion, transcutaneous pacemaker, transvenous pacemaker, or permanent pacemaker).

ECC-C COMPLICATIONS

OUTCOME: The parent and/or family will understand the effects and consequences of ECC on their child.

STANDARDS:

1. Review the consequences of severe tooth decay, i.e., infection, tooth loss, speech problems, aesthetics.
2. Review treatment modalities (tooth restoration, behavior management).
3. Review the health risks of general anesthesia.
4. Review the costs of extensive treatment.

ECC-DP DISEASE PROCESS

OUTCOME: The parent and/or family will understand the causes, identification, and prevention of Early Childhood Caries (ECC).

STANDARDS:

1. Review the current factual information regarding the causes of ECC.
2. Discuss how dental disease germs can be passed from parent to infant.
3. Discuss the role of sugar.
4. Review how to identify early signs of ECC.

ECC-FU FOLLOW-UP

OUTCOME: The parent and/or family will understand the importance of infant and early childhood oral health care including dental well checks.

STANDARDS:

1. Discuss dental well child visits.
2. Review recommendations for early childhood dental care.
3. Discuss the importance of follow up in patients who have developed dental disease.

ECC-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent and/or family will understand that primary dentition begins to develop during fetal life and that primary teeth serve several purposes.

STANDARDS:

1. Review primary tooth development.
2. Discuss the role of primary teeth in the growth and development of the mandible, maxilla, and permanent teeth.

ECC-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

ECC-LA LIFESTYLE ADAPTATIONS

OUTCOME: The parent and/or family will understand how to avoid the disease, adopt good feeding practices, avoid falling prey to old habits and develop positive oral hygiene habits.

STANDARDS:

1. Discuss attitudes toward feeding habits.
2. Review breast-feeding and bottle feeding practices.
3. Provide information on alternatives to misuse of baby bottles, i.e., no bottles in the bed, no propping of bottles, weaning at 12 months of age.

ECC-N NUTRITION

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

STANDARDS:

1. Review normal nutritional needs for optimal general and dental health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss nutritional modifications as related to Early Childhood Caries.
4. Emphasize the importance of adherence to the prescribed nutritional plan.

ECC-P PREVENTION

OUTCOME: The parent and/or family will understand how to prevent ECC.

STANDARDS:

1. Review adult oral hygiene with the parent.
2. Review infant/child oral hygiene, i.e., the use of a soft washcloth to clean the gums of infants.
3. Discuss methods of prevention, including fluoride supplementation and limitation of sugar in diet.
4. Explain to parents the methods of early identification of dental disease in infants and small children. Explain the importance of early treatment.
5. Review proper use of and alternatives to misuse of the bottle or nipple, i.e., no bottles in bed, no propping of bottles, and weaning at 12 months of age.
6. Emphasize that nothing should be given from a bottle except formula, breast milk, water, or electrolyte solution, i.e., no juice or soda pop.

ECC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of 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, i.e., avoid hot and cold foods.

ECC-PRO PROCEDURES

OUTCOME: The patient/family will understand procedure(s) to be performed to treat ECC and the risk of not treating ECC.

STANDARDS:

1. Explain the procedures proposed as well as alternatives and/or the risk of doing nothing.
2. Discuss common and important complications of treatment or non-treatment.

ECC-TE TESTS

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

STANDARDS:

1. Discuss the test(s) to be performed (x-ray, etc.).
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.

ECC-TX TREATMENT

OUTCOME: The patient will understand the necessary treatment (filling, capping, etc.) and the proper oral care after treatment.

STANDARDS:

1. Explain the basic procedure to be used (filling, capping, etc.) and the indication, common complications and alternatives as well as the risks of non-treatment.
2. Review the specific elements of oral care after treatment. **Refer to [DC](#) and [ECC-P](#).**
3. Discuss the indications for returning to the provider, i.e., bleeding, persistent or increasing pain, and fever.

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 adherence 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 strict adherence 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 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 have an understanding of 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, etc.
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, etc.
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.

ELD-DP DISEASE PROCESS/AGING

OUTCOME: The patient/family will have an understanding of the normal aging process and will develop an action plan to maintain optimal health while aging.

STANDARDS:

1. Explain the normal anatomy and physiology of the aging process:
 - a. it is normal to slow down as one ages
 - b. some lapses in short-term memory are common
 - c. some decrease in sex drive and ability to perform are common
 - d. changes in sleeping patterns are common
 - e. presbyopia (far sightedness) is nearly universal as humans age.
2. Explain that older individuals often have several chronic diseases that may need special attention in light of their advanced age.
3. Depression is common and may be difficult to diagnose. Family and caregivers should be instructed to watch for signs of depression, i.e., loss of appetite, social withdrawal, etc.

ELD-EX EXERCISE

OUTCOME: The patient/family/caregiver will understand that continued physical activity may offset some common problems of aging.

STANDARDS:

1. Explain the importance of physical activity in maintaining health.
2. Emphasize the importance of evaluation by a physician prior to starting a new exercise program.
3. Discuss recommended activity level including any restrictions on activity.
4. Explain that chest pain experienced during exercise should be immediately evaluated by a health care provider.

ELD-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand their responsibility in health maintenance and the importance of keeping follow-up appointments.

STANDARDS:

1. Explain the procedure for obtaining follow-up appointments.
2. Emphasize the importance of keeping appointments.
3. Discuss the importance of bringing all medications to each visit.
4. Stress the importance of adherence with the health maintenance plan between visits.
5. Emphasize the importance of regular health screening for older adults, i.e., colonoscopy, mammograms, pap smears, PSAs, etc.
6. Refer to community resources as appropriate, i.e., meals on wheels, elder transportation vans, Medicare, etc.

ELD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family caregiver will receive written information about aging or elder health care issues.

STANDARDS:

1. Provide the patient/family/caregiver with written patient information about aging or elder health care issues.
2. Discuss the content of the patient information literature with the patient/family/caregiver.

ELD-LA LIFESTYLE ADAPTATIONS

OUTCOMES: The patient/family/caregiver will have an understanding of the lifestyle adjustments needed to maintain optimal health and will develop a plan to modify behavior where needed.

STANDARDS:

1. Assess the patient/family/caregiver level of understanding and acceptance of the aging process.
2. Refer to Social Services, Mental Health, Physical Therapy, Rehabilitative Services and/or other resources as appropriate.
3. Review the lifestyle areas that may require adaptations: diet, physical activity, sexual activity, bladder/bowel habits, role changes, communication skills and interpersonal relationships, transportation issues, isolation issues, etc.

ELD-M MEDICATIONS

OUTCOMES: The patient/family/caregiver will develop a plan for the patient taking prescribed medications correctly.

STANDARDS:

1. Review the patient's medication regimen.
2. Suggest techniques to ensure that medications are taken correctly, i.e., weekly medicine dispensing boxes, written lists, etc.
3. Emphasize the importance of taking all medications to each visit.
4. Emphasize the importance of medication adherence.
5. Consider community health nursing referral to assess the elder patient's ability to comply with taking their medications correctly, as appropriate.

ELD-N NUTRITION

OUTCOME: The patient/family/caregiver will understand dietary requirements for optimal health in this patient.

STANDARDS:

1. Assess nutritional status using 24-hour diet recall or other tool.
2. Discuss this patient's specific nutrition plan.
3. Identify problems such as dental or gum disease, financial limitations, cognitive limitations or other conditions which may limit the patient's ability to achieve good nutrition. Refer as appropriate.

ELD-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.
2. Assist the patient/family/caregiver in identifying ways to adapt the home to improve safety and prevent injuries (remove throw rugs, install bars in tub/shower, secure electrical cords, install ramps, etc.).
3. As appropriate, stress the importance of mobility assistance devices such as canes, walkers, wheel chairs, therapeutic shoes, etc.
4. Discuss the current/potential abuse of alcohol or drugs.
5. Emphasize the importance of NEVER smoking in bed. Refer to smoking cessation programs as appropriate.
6. Discuss the potential for elder abuse/neglect (including financial exploitation) and ways to identify abuse/neglect. Refer as appropriate.

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 verbalize understanding 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 and 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 and 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 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.

EOL-M MEDICATION

OUTCOME: The patient/family will understand the role of medication in control of pain and other discomforts. The patient and family will verbally summarize the medication regimen and the importance of adherence 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 and family concerns about addiction. Explain that addiction is not an issue for terminally ill patients.
7. Discuss the importance of adherence 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 and 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 have an understanding of 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, adherence 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 such as support groups, individual therapy, family counseling, spiritual counseling, etc. Refer 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.

EYE-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient and/or family will have a basic understanding of the anatomy and physiology of the eye and surrounding tissues as it relates to the specific eye condition.

STANDARDS:

1. Explain the normal anatomy and physiology of the eye.
2. Discuss the changes to the anatomy and physiology as a result of the specific eye condition.
3. Discuss the impact of these changes on the patient's vision and health.

EYE-C COMPLICATIONS

OUTCOME: The patient/family will have an understanding of the potential complications of their ocular condition.

STANDARDS:

1. Review the effects that this condition has on the patient's ocular status. Emphasize the short/long-term effects and the degree of control that the patient has over the progression of the condition.
2. Discuss symptoms which may indicate progression of the condition.

EYE-DP DISEASE PROCESS

OUTCOME: The patient/family will have an understanding of their ocular condition.

STANDARDS:

1. Review the current information about the patient's specific condition.

EYE-FU FOLLOW-UP

OUTCOME: The patient/family will understand the need and process for obtaining and complying with follow-up for their condition.

STANDARDS:

1. Discuss the patient's responsibility in the management of his/her condition.
2. Emphasize the importance of making and keeping appropriate follow-up appointments.

EYE-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of their specific eye condition 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.

EYE-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about his/her ocular condition.

STANDARDS:

1. Give the patient/family written information about his/her ocular condition.
2. Discuss the information with the patient/family.

EYE-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will strive to make the lifestyle adaptations necessary to prevent complications of the specific eye condition and improve overall health.

STANDARDS:

1. Review the lifestyle aspects/changes that the patient has control over - diet, exercise, safety and injury prevention, avoidance of high risk behaviors, and adherence with the treatment plan.
2. Emphasize that an important component in the treatment of the specific eye condition is the patient's adaptation to the treatment plan.
3. Review the community resources available to assist the patient in making lifestyle changes and make referrals as appropriate.

EYE-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. Discuss, and demonstrate as appropriate, 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.
2. Emphasize the importance of adherence with the 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 nonprescription or traditional remedies, to the provider.

EYE-P PREVENTION

OUTCOME: The patient/family will understand that healthy lifestyle behaviors can reduce the risk of developing some eye conditions and complications.

STANDARDS:

1. List lifestyle habits that increase the risk for the onset or progression of the specific eye condition.
2. Identify behaviors that reduce the risk for the onset or progression of a specific eye condition, i.e., proper nutrition, safety and infection control practices.
3. Assist the patient in developing a plan for prevention of the specific eye condition.

EYE-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the pain management techniques for this particular eye condition.

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. Discuss pharmacologic pain management strategies as appropriate, i.e., eye drops, oral pain medicine.
3. Explain that short term use of narcotics may be helpful in pain management as appropriate.
4. Discuss non-pharmacologic measures that may be helpful with pain control, warm or cool packs, etc.

EYE-TE TESTS

OUTCOME: The patient/family will have an understanding of the test(s) to be performed including indications and its 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.
4. Explain the meaning of the test results.

EYE-TX TREATMENT

OUTCOME: The patient/family will have an understanding of the common and important risks, anticipated benefits, and anticipated progress of the condition.

STANDARDS:

1. Review the current information regarding the treatment of the condition with the patient/family.
2. Explain indications, benefits, and common or important risks of the proposed treatment.
3. Help the patient/family develop a treatment plan which will achieve the goal(s) of treatment.

FALL-C COMPLICATIONS

OUTCOME: The patient/family will understand that the complications from falls may be serious.

STANDARDS:

1. Explain that falls may result in minor injuries including lacerations, abrasions and contusions.
2. Explain that falls may also result in major injuries that may be life-threatening and may include head injuries and fractures.

FALL-DP DISEASE PROCESS

OUTCOME: The patient/family will understand that some patients are at higher risk for falls because of mental status, disease processes, age or medications.

STANDARDS:

1. Explain that some medications, such as tranquilizers, sedatives, pain medications, antihypertensives, or diuretics may cause dizziness and disorientation.
2. Explain that illness, therapeutic procedures and diagnostic tests may leave the patient weak and unsteady.
3. Explain that the hospital may seem unfamiliar, especially when awakened at night, and this, combined with other factors, may result in disorientation.
4. Explain that some disease processes such as neurologic disorders, cognitive impairment, changes in mental status, generalized weakness, dizziness, and advanced age may predispose to falls.
5. Discuss that infants and small children may be at increased risk of injury from falls.

FALL-FU FOLLOW-UP

OUTCOME: The patient/family will understand that consultation with a physician after a fall where injury is suspected or known is important to insure that appropriate treatment for injuries is provided.

STANDARDS:

1. Discuss that consultation with a physician after a fall where injury is suspected or known is important to insure that appropriate treatment for injuries is provided.
2. Discuss the importance of keeping follow-up appointments as scheduled or recommended.

FALL-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive literature regarding the prevention of falls.

STANDARDS:

1. Provide patient/family with written literature regarding the prevention of falls.
2. Discuss the content of the literature regarding the prevention of falls with the patient/family.

FALL-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand measures that may be taken to prevent falls.

STANDARDS:

1. Explain that wearing non-skid slippers when out of bed may prevent slipping and falling.
2. In the home or in the hospital stress the importance of calling for help or using the call light or other call devices to call for assistance if dizziness and/or weakness are experienced.
3. Emphasize that in hospitals or nursing homes, nursing staff are available for assistance in getting out of bed and to help with ambulation and personal care needs.
4. Explain that, after lying in bed, being ill, or taking certain medications, dizziness may result from getting up too suddenly. Instruct the patient to sit up slowly and to sit a few minutes before slowly standing and walking.
5. As appropriate, instruct the patient/family not to tamper with the side rails that may be in use. Side rails are reminders to stay in bed and are designed to ensure safety.
6. If the patient must get up before assistance arrives, instruct the patient to walk slowly and carefully and not to use rolling objects such as bedside tables as support.
7. Discuss that throw rugs, wires across the floor, objects on the floor, unlevel floors, wet or moist floors, uneven carpeting, pets in the home, small children playing in the floor stairs, and shoes with heels or slick soles pose high fall risks. Instruct the patient to remove as many of these obstacles as possible.

FP-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient will have a basic understanding of anatomy and physiology and its relationship to reproduction.

STANDARDS:

1. Identify and explain the functions of the reproductive system.
2. Discuss the menstrual cycle.
3. Discuss conception vs. contraception.

FP-DIA DIAPHRAGM

OUTCOME: The patient will have an understanding of the safe and effective use of a diaphragm.

STANDARDS:

1. Discuss the method of insertion.
2. Emphasize the use of spermicide.
3. Discuss the amount of time the diaphragm must be left in place.
4. Emphasize that the diaphragm must be used each time intercourse takes place.
5. Emphasize that the diaphragm must be refitted if there is a 10 pound weight loss or gain, and after childbirth.

FP-DPO DEPOT MEDROXYPROGESTERONE INJECTIONS

OUTCOME: The patient will have an understanding of risks, benefits, side effects, and effectiveness of depot medroxyprogesterone injections.

STANDARDS:

1. Explain the method of action and effectiveness of depot medroxyprogesterone.
2. Discuss the method of administration and importance of receiving the medication on time (typically every 3 months).
3. Discuss the contraindications, risks, and side effects of the medication.

FP-FC FOAM AND CONDOMS

OUTCOME: The patient will have a basic understanding of the safe and effective use of foam and condoms.

STANDARDS:

1. Discuss proper use and application of foam and condoms.
2. Emphasize the importance of use each time intercourse takes place.
3. Emphasize why condoms must be applied before penetration.
4. Emphasize that male must withdraw before erection subsides.
5. Advise concomitant use of spermicidal foam as recommended by the medical provider.
6. Discuss use of spermicidal suppositories.
7. Discuss that condoms provide possible protection against STD's.

FP-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.

FP-IC IMPLANT CONTRACEPTION

OUTCOME: The patient will have an understanding of the safe and effective use of implantable contraceptives.

STANDARDS:

1. Discuss and review all birth control methods with the patient.
2. Explain the insertion procedure and mechanism of action including duration of effectiveness.
3. Discuss contraindications, risks, and side effects, including the possibility of pregnancy.
4. Stress the importance of yearly follow-up.

FP-IUD INTRAUTERINE DEVICE

OUTCOME: The patient will have an understanding of the safe and effective use of the IUD.

STANDARDS:

1. Explain why IUDs are more easily retained in multiparous vs. nulliparous women.
2. Explain how IUDs work.
3. Emphasize the importance of monthly string checks.
4. Emphasize the importance of reporting abnormal vaginal discharge, fever, or pain with intercourse.
5. Discuss contraindications to placement of IUDs.
6. Explain that the copper IUD's need periodic replacement.

NOTE: IUDs may be UNAVAILABLE from time to time due to medicolegal reasons.

FP-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

FP-MT METHODS

OUTCOME: The patient will receive information regarding the available methods of birth control.

STANDARDS:

1. Discuss the reliability of the various methods of birth control.
2. Discuss how each method is used in preventing pregnancy.
3. Discuss contraindications, benefits, and potential costs of each method.

FP-N NUTRITION

OUTCOME: The patient will understand the role of folic acid in the prevention of neural tube defects and the importance of a balanced diet.

STANDARDS:

1. Identify the amount of folic acid required.
2. Explain that to be maximally effective, folic acid should be given before conception.
3. Identify food sources and supplemental forms of folic acid.
4. Discuss the importance of a balanced diet.

FP-OC ORAL CONTRACEPTIVES

OUTCOME: The patient will have an understanding of the safe and effective use of oral contraceptives.

STANDARDS:

1. Explain how the “pill” inhibits ovulation.
2. Discuss the methods of taking oral contraceptives.
3. Discuss the contraindications, risks, and side effects.
4. Discuss the signs and symptoms of complications.
5. Specifically counsel on potential drug interactions, especially that antibiotics may make the contraceptive ineffective.

FP-ST STERILIZATION

OUTCOME: In order to make an informed decision about irreversible contraception, the patient will receive information about sterilization.

STANDARDS:

1. Explain tubal ligation vs. vasectomy. Emphasize that these are PERMANENT methods of contraception.
2. Explain laparoscopic (LEC) procedures: Anesthesia, CO2, incision, vaginal bleeding.
3. Explain vasectomy procedures.
4. Discuss the possible side effects and risks: Infection, pain, failure, and bleeding at incision site.
5. Explain that IHS and the state may have specific legal criteria that must be met in order to be eligible for sterilization.
6. Review availability of other methods that can prevent or delay pregnancy as an option to permanent sterilization.
7. Offer behavioral health follow-up as appropriate.

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-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 (acetaminophen, ibuprofen, etc.) 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 (antipyretics combined with decongestants, etc) 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.)

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-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. windchill 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 and family with written information on frostbite and prevention of frostbite.
2. Discuss the content of frostbite written information with the patient and family.

FRST-M MEDICATIONS

OUTCOME: The patient and 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 have an understanding of 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 dietician as appropriate.

FRST-P PREVENTION

OUTCOME: The patient and family will understand ways to prevent frostbite.

STANDARDS:

1. Discuss with the patient and 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 and 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 have an understanding of 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 (within 5-10 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 have an understanding of the necessity and procedure for proper wound care.

STANDARDS:

1. Explain the reasons to care appropriately for the wound; decreased infection rate, improved healing, etc.
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.
6. Demonstrate the necessary wound care techniques.

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 verbalize understanding of 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 cholecystitis 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 adherence to 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 verbalize an understanding of 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 have an understanding of 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-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-DP DISEASE PROCESS

OUTCOME: The patient will verbalize understanding of 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 adherence to 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 verbalize understanding of 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 have an understanding of 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 TESTING

OUTCOME: The patient /family will understand the conditions under which testing is necessary and the specific test(s) to be performed, 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-DP DISEASE PROCESS

OUTCOME: The patient will have an understanding of 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.
3. Identify obesity as a major exacerbating factor in GERD. Discuss the importance of regular exercise and its role in obtaining and maintaining desirable weight.
4. Identify foods that may aggravate GERD.
5. Review the effect of timing of meals, i.e., no large meals before bedtime, more frequent light meals instead of few large meals.
6. Discuss physical control measures such as elevating the head of the bed.

GER-M MEDICATIONS

OUTCOMES: Patient/family will verbalize an understanding of 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 verbalize understanding of 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 adherence to the prescribed nutritional plan.

GER-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of 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-TE TESTS

OUTCOME: The patient/family will have an understanding of 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 have an understanding of 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-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-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 (fast walking, bicycling, running, swimming laps, etc.) daily is usually enough to result in improvement in GAD symptoms.
4. Explain that other forms of exercise (weight-lifting, sit-ups, etc.) 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 (gardening, house cleaning, dancing, etc.).
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.

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. For example, the patient may keep most of the medication in a locked cabinet and carry only a small amount in his/her pocket, purse, etc. 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-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 adhere to 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-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-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 –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 adherence.

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 adherence with the medication regimen in order to promote healing and assure optimal comfort.

GIB –N NUTRITION

OUTCOME: The patient/family will verbalize an understanding of 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 have an understanding of 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 have an understanding of 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.

GL-DP DISEASE PROCESS

OUTCOME: The patient will understand the complications and progression of glaucoma.

STANDARDS:

1. Explain that glaucoma is characterized by an increase in intraocular pressure.
2. Explain that untreated glaucoma will result in permanent loss of vision due to optic nerve damage.
3. Explain that in early glaucoma there are usually no symptoms.
4. Explain that the acute-angle closure form of glaucoma may occur at any age and may include eye pain, light sensitivity, blurred vision, halos, or nausea and vomiting.

GL-FU FOLLOW-UP

OUTCOME: The patient will verbally summarize their knowledge of their present glaucoma status and understand the importance of regular follow-up in the control of glaucoma.

STANDARDS:

1. Discuss that frequent examinations are required to monitor for side effects of treatment or disease progression.
2. Discuss the status of the ocular condition and the potential to maintain, lose or regain the quality of ocular health and visual capabilities.

GL-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

GL-LT LASER THERAPY

OUTCOME: The patient will understand how laser therapy prevents progression of the disease.

STANDARDS:

1. Explain the preparation for the laser procedure.
2. Explain how the laser prevents worsening of the condition.
3. Discuss the common side effects and major complications of the procedure.

GL-M MEDICATIONS

OUTCOME: The patient will understand the importance of treatment and make a plan to comply with the treatment regimen.

STANDARDS:

1. Discuss the medication options for glaucoma treatment.
2. Explain that glaucoma may progress slowly and asymptotically and that adherence with treatment will halt progression of disease and preserve vision.
3. Discuss the use, benefits, and common side effects of the patient's prescribed medications.
4. Have the patient demonstrate proper use of eye drops.
5. Assist with development of a plan for adherence as appropriate.

GBS-C COMPLICATIONS

OUTCOME: The patient/family will understand the effects and consequences possible as a result of Guillain-Barre Syndrome and understand that adherence to 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-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 adherence to 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 have an understanding of 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 have an understanding of 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.

HRA-EQ EQUIPMENT

OUTCOME: The patient/family will verbalize understanding of the types and features of hearing aids and will participate in the choice of hearing aids for his/her own use. The patient/family will understand proper operation and care of the hearing aid.

STANDARDS:

1. Explain the types and sizes of hearing aids available: behind-the-ear, in-the-ear, in-the-canal, completely in the canal (CIC), programmable, digital, etc.
2. Explain features available on hearing aids: telecoils, vents, shell materials, markings, removal handles, special circuitry, etc.
3. Discuss specific recommendations for the patient.
4. Explain the parts of the hearing aids and have the patient/family practice operation of the hearing aids.
5. Explain care and maintenance of the hearing aids.

HRA-FU FOLLOW-UP

OUTCOME: The patient and/or family will understand the importance of follow-up in the treatment of hearing loss.

STANDARDS:

1. Discuss the importance of follow-up care, including the importance of assessing the effectiveness of hearing aids and correcting problems which may develop.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.
4. Make referrals as appropriate.

HRA-L PATIENT INFORMATION LITERATURE

OUTCOME: Patient will receive written information about hearing loss, hearing aid use, or communication strategies.

STANDARDS:

1. Provide the patient/family with written patient information literature on hearing loss, hearing aid use, or communication strategies.
2. Discuss the content of the patient information literature with the patient/family.

HRA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand communication and lifestyle adaptations that will optimize the patient's ability to actively participate in communication using hearing aids.

STANDARDS:

1. Discuss the role of hearing aids, speech-reading, speech characteristics, and control of environmental factors in the communication process.
2. Refer to community resources as appropriate.

HL-DP DISEASE PROCESS

OUTCOME: The patient/family will verbalize some causes of hearing loss.

STANDARDS:

1. Explain the basic anatomy and physiology of hearing.
2. Explain the type and cause(s) of the patient's hearing loss if known.

HL-EQ EQUIPMENT

OUTCOME: The patient/family will verbalize understanding and demonstrate (when appropriate) proper use and care of equipment used in hearing loss.

STANDARDS:

1. Discuss equipment to be used in hearing loss. **Refer to [HRA](#).**
2. Discuss and/or demonstrate proper use and care of equipment; participate in return demonstration by patient/family as appropriate.
3. Emphasize proper cleaning of equipment.

HL-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of hearing loss.

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. Make referrals as appropriate.

HL-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

HL-SL SPEECH AND LANGUAGE SCREENING

OUTCOME: The parent will verbalize understanding of the relationship between hearing ability and the development of speech and language skills.

STANDARDS:

1. Explain that the ability to hear is necessary to develop speech/language skills.
2. Discuss the child's current level of speech/language development.
3. Refer to the local public school or other community resources as appropriate.

HL-TE TESTING

OUTCOME: The patient/family will verbalize understanding of the results of the audiogram or other hearing test.

STANDARDS:

1. Explain the patient's hearing test results.
2. Explain the relationship between the test results and communication abilities.

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-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 stroke: 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, anhidrosis 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 have an understanding of how heatstroke can be influenced by exercise.

STANDARDS:

1. Discuss with patient and 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 and family with written information on heatstroke and prevention of heatstroke.
2. Discuss the content of heatstroke written information with the patient and family.

HEAT-M MEDICATIONS

OUTCOME: The patient and 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 and 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 and 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 and 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-TX TREATMENT

OUTCOME: The patient and/or family will have an understanding of 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 and 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-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family/caregiver will have an understanding of 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 have an understanding of 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-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 and 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 and 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 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 TESTING

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 have an understanding of 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-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.
2. Discuss common or significant complications which may be prevented by adherence with the treatment regimen.
3. Discuss common or significant complications that may result from treatment(s).

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, vaginal fluids, mother to infant.
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.
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 adherence 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-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.
3. Discuss the importance of hand washing in infection control.
4. If using IV drugs, discuss the importance and implications of not sharing needles.
5. Discuss the importance and implications of preventing unprotected sexual activity.
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 diseases (STD).

STANDARDS:

1. Provide the patient/family with written patient information literature on HIV and/or other sexually transmitted diseases.
2. Discuss the content of patient information literature with the patient/family.

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 adherence 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.

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 adherence 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, complementary medicine or traditional remedies, to the provider.

HIV-N**NUTRITION**

OUTCOME: The patient will verbalize understanding of 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 adherence to the prescribed nutritional plan.
6. Emphasize the importance of food safety.
7. Discuss nutrition supplements, i.e., vitamin and mineral supplements, antioxidants, complementary supplements, etc.

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 condoms and nonoxonyl-9 or tother protective agents.
 - 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 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 adherence 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-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 adherence 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.

HIV-TX TREATMENT

OUTCOME: The patient/family will understand the importance of a comprehensive treatment plan.

STANDARDS:

1. 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.
2. Discuss the process for developing a comprehensive treatment plan.
3. Help the patient/family identify the appropriate resources for developing a comprehensive treatment plan.
4. Explain that identification of all partners is necessary to facilitate the treatment of those persons and limit further spread of the infection.

HTN-C COMPLICATIONS

OUTCOME: The patient will verbally summarize 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-DP DISEASE PROCESS

OUTCOME: The patient will verbally define 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 such as stores, etc.
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 will understand the relationship of exercise to normal blood pressure.

STANDARDS:

1. Explain how regular exercise helps to reduce high blood pressure and maintain normal blood pressure.
2. Refer to [WL-EX](#).
3. Discuss activity allowances and expectations (heavy lifting may predispose to complications).

HTN-FU FOLLOW-UP

OUTCOME: The patient participates in the treatment plan and understands the importance of adherence.

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 have an understanding of 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 adherence 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.

HTH-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will verbalize 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 verbalize an understanding of 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 verbalize 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, complying 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 verbalize an understanding of 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 adherence to 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 dietician as appropriate.

HTH-TE TESTS

OUTCOME: The patient/family will verbalize an understanding of 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 (TSH, T3, T4, nuclear scan, ultrasound, etc.).
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 verbalize an understanding of 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.

LTH-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will verbalize 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 verbalize an understanding of 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 adherence 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 verbalize 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 verbalize an understanding of 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. Review the basic exercise or activity recommendations for the treatment plan.
3. 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.
4. Assist the patient/family in developing an appropriate physical activity plan.
5. Refer to community resources as appropriate.

LTH-FU FOLLOW-UP

OUTCOME: The patient/family will verbalize an understanding of 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, complying 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 have an understanding of 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 verbalize an understanding of 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 adherence to 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 verbalize an understanding of 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 dietician.

LTH-TE TESTS

OUTCOME: The patient/family will verbalize an understanding of the tests to be performed.

STANDARDS:

1. Explain the test ordered (TSH, T3, T4, nuclear scan, ultrasound, blood counts, etc.).
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.

IM-DEF DEFICIENCY

OUTCOME: The patient/family will understand the importance of complying 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 important and common side effects of immunizations to be administered.
3. Explain post-immunization care including dose of antipyretics if needed and what to do if serious side effects are observed.

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.

IM-SCH SCHEDULE

OUTCOME: The patient/family will understand the importance of complying with schedule of prescribed immunizations for protection from vaccine preventable diseases.

STANDARDS:

1. Explain that vaccines are prescribed to be given in series, within certain time frames.
2. Explain that some vaccines are required by law.
3. Provide schedules on types of vaccines for children and adults.

IGT-C COMPLICATIONS

OUTCOME: The patient/family/caregiver will understand common or serious complications of fasting blood glucose levels that stay above normal (70-110 mg/Dl) but less than 125 mg/dl and that IGT typically progresses to Type 2 Diabetes.

STANDARDS:

1. Emphasize that good control of blood sugar can reverse or prevent progression of IGT.
2. Emphasize that good control of blood sugar can dramatically reduce the risk of complications.
3. State that IGT is a disease that needs to be monitored for progression and complications. Routine examinations are essential.
4. Discuss higher risk factors of IGT (heart attack, stroke, etc.) **Refer to [CVA](#), [CAD](#), [DM](#) and [PVD](#).**
5. Discuss complications that can occur if IGT develops into Diabetes (heart disease, stroke, eye problems, kidney damage, etc.).

IGT-DP DISEASE PROCESS

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

STANDARDS:

1. Briefly describe the pathophysiology of IGT.
2. Discuss the role of insulin resistance in IGT and Type 2 DM.
3. Describe risk factors for development and progression of IGT, i.e., including: family history, obesity, sedentary lifestyle, previous history of gestational diabetes, history of high blood pressure, high triglycerides.
4. Emphasize that IGT is a reversible, controllable condition, which requires permanent lifestyle alterations and continuous attention and medical care. **Refer to [IGT-LA](#).**

IGT-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 regular exercise will reduce the body's resistance to insulin.
2. Explain that the goal is at least 20-30 minutes of aerobic exercise at least 6 times per week.
3. Encourage the patient to begin exercise at a comfortable level and increase the frequency, intensity, and duration of the activity as he/she becomes fit.
4. Assist the patient in developing a personal exercise plan. **Refer to [WL-EX](#).**
5. Discuss potential obstacles to a personal exercise plan and solutions to these obstacles.

IGT-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in preventing the progression of IGT . 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 IGT to Type 2 Diabetes.
2. Discuss the procedure for making appointments.
3. Discuss any necessary preparation for lab test(s). **Refer to [IGT-TE](#).**

IGT-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

IGT-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family/caregiver will understand the lifestyle adaptations necessary to prevent or delay the progression of IGT 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, etc., 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.

IGT-N NUTRITION

OUTCOME: The patient/family will understand the importance of nutritional management in the control of IGT and develop a plan to meet nutritional goals.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation and responsible eating.
2. Review the food pyramid and its role in meal planning. Refer to 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 (broiling or baking is preferred over frying, avoid gravies and sauces, rinsing or blotting excess grease, etc.).
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 complex carbohydrates and low-fat proteins are preferred and that sugars and fats should be limited.
8. Emphasize the importance of family involvement and early intervention.

IGT-P PREVENTION

OUTCOME: The patient/family will understand major risk factors for development of IGT and will develop a plan for risk reduction.

STANDARDS:

1. Discuss the risk factors for IGT and Type 2 DM, i.e., obesity, sedentary lifestyle.
2. Explain that following the ‘Food Guide Pyramid’ and maintaining adequate activity levels will reduce the risk of progression of IGT to Type 2 Diabetes.
3. Emphasize the importance of regular screening. Discuss current recommendations for screening.

IGT-TE TESTS

OUTCOME: The patient/family will have an understanding of the test to be performed and the reasons for the testing.

STANDARDS:

1. Explain the test(s) ordered (FBS, HgbA_{1C}, Fasting Lipid Profile, etc.).
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.

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 adherence.

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 adherence 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, etc.

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 (contaminated objects such as telephone receivers etc.), and that common use of disinfectant cleaners may reduce this spread.

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 verbalize understanding 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 adherence 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 have an understanding of 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-WC WOUND CARE

OUTCOME: The patient/family will have an understanding of 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; decreased infection rate, improved healing, etc.
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.

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 (gloves, etc.) 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.

PB-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and important complications of lead exposure and lead toxicity.

STANDARDS:

1. Discuss the effects of lead on neurobehavioral systems as per current medical understanding. (As of 5-2003 it is thought that even low levels of lead exposure, i.e., less than 10F g/dl can result in subtle neurobehavioral changes such as hyperactivity, lower IQ levels and poor school performance.)
2. Explain that older children and adults with high bone lead levels may exhibit aggressive behavior and antisocial behaviors.
3. As appropriate, discuss the effects of long term high levels of lead exposure. These may include vomiting, abdominal pain, constipation, ataxia, seizures, papilledema, impaired consciousness and eventually coma. The latter of these symptoms are associated with acute lead encephalopathy.

PB-DP DISEASE PROCESS

OUTCOME: The patient/family will understand how humans are exposed to lead and the effects of lead on humans.

STANDARDS:

1. Discuss that lead is most often introduced to humans via hand-to-mouth activity of young children, either as ingested dirt, dust licked off surfaces (including toys) and ingested paint chips. Less commonly lead may be ingested from water flow through lead pipes or brass fixtures, or from food served or prepared in ceramic bowls which have a lead glaze.
2. Discuss that the nutritional status of the individual impacts the amount of lead that is absorbed, i.e., lead ingested on an empty stomach is more likely to be absorbed than if the stomach is full. Calcium and iron may decrease lead absorption by direct competition for binding sites. Iron and/or calcium deficiency are likely to cause an individual to have enhanced lead absorption.
3. Explain that lead interrupts several chemical systems in the body and can lead to toxic levels of other chemicals in addition to the lead. Lead directly interferes with neurotransmitter release in the brain and may directly affect the developmental structure of the brain in utero and in the first few years of life. This latter effect may be an irreversible effect.

PB-FU FOLLOW-UP

OUTCOME: The patient/family 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 and routine screening for high risk populations.
2. Refer to PHN or community resources as appropriate.

PB-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about lead exposure and lead toxicity.

STANDARDS:

1. Provide the patient/family with written patient information literature on decreasing lead exposure, lead toxicity, and or lead abatement programs.
2. Discuss the content of the patient information literature with the patient/family.

PB-N NUTRITION

OUTCOME: The patient/family will understand the importance of proper nutrition in prevention and treatment of lead toxicity.

STANDARDS:

1. Discuss that the nutritional status of the individual impacts the amount of lead that is absorbed, i.e., lead ingested on an empty stomach is more likely to be absorbed than if the stomach is full. Discuss that calcium and iron may decrease lead absorption by direct competition for binding sites.
2. Discuss that iron and/or calcium deficiency are likely to cause an individual to have enhanced lead absorption.
3. Refer to the registered dietician and/or physician if a calcium or iron deficiency is present or suspected.

PB-P PREVENTION

OUTCOME: The patient/family will understand mechanisms to prevent or limit exposure to lead.

STANDARDS:

1. Review nutritional mechanisms to decrease lead absorption. **Refer to [PB-N](#).**
2. Discuss mechanisms to decrease lead exposure:
 - a. Wash your hands before you eat.
 - b. Take your shoes off at the door to avoid tracking in possibly contaminated dust.
 - c. Consult the health department before remodeling homes built before 1978.
 - d. Avoid eating dirt or paint chips.
 - e. Avoid eating out of pottery which may have been glazed with a lead-based glaze.
 - f. Avoid home remedies, especially from foreign lands such as Asia or Mexico. (Azarcon, greta, rueda all may contain lead.)
 - g. Avoid eating candies, syrups or vanilla manufactured in Mexico or South America.
 - h. Avoid crayons not manufactured in the United States.
 - i. Avoid mini-blinds which do not have a label indicating that they are lead-free.
3. Explain the importance of removing lead from clothing, shoes and your body if you work in an industry where lead exposure is likely.

PB-SCR SCREENING

OUTCOME: The patient/family will understand the importance of routine screening for high risk populations and who is at highest risk for lead exposure.

STANDARDS:

1. Discuss that the following persons are at highest risk for lead exposure:
 - a. Live in or regularly visit a house or day care built before 1950 (especially if there is chipping or peeling paint.)
 - b. Live in or regularly visit a house built before 1978 that has been recently remodeled (in the last 6 months.)
 - c. Engage in frequent hand-to-mouth activity
 - d. Have iron deficiency or anemia
 - e. Live with an adult with a job or hobby that involves exposure to lead
 - i. Pottery or stained glass
 - ii. Bridge construction
 - iii. Battery recycling
 - iv. Paint and body work on cars or equipment
 - v. Furniture manufacturing
 - vi. Bullet or fishing weight casting
 - f. Have siblings or playmates that have or have had lead poisoning
 - g. Live in an area that is known to be contaminated with lead.
2. Discuss the importance of routine screening for all persons in high risk populations.
 - a. Routine screening is typically performed at 6 months of age, one year of age and annually through 6 years of age (when hand-to-mouth activity generally decreases):
 - i. In older children with mental retardation who may have prolonged hand-to-mouth activity
 - ii. In pregnancy
 - iii. When deemed appropriate by a healthcare provider
 - iv. If requested by a patient or caregiver.

PB-TE TESTS

OUTCOME: The patient/family will understand the type of lead testing to be done and the implication this has for future testing or treatment.

STANDARDS:

1. Explain that lead testing can be done utilizing a variety of specimens.
2. Explain the test to be performed as well as alternative testing mechanisms as appropriate:
 - a. Capillary blood testing - usually a screening method and will need to be confirmed with venous blood analysis if the level is greater than 10Fg/dl
 - b. Venous blood testing - used as a confirmatory test upon which future testing or treatment will be based
 - c. Urinary lead levels - usually used during chelation therapy to determine the response to therapy
 - d. Hair lead levels - unreliable secondary to likelihood of contamination or lack of standardized interpretation tools.
 - e. Discuss as appropriate the CDC's recommendation for follow-up testing and/or treatment based on venous blood lead levels.
 - f. 10-19Fg/dl repeat venous level in 3 months, try to identify sources of lead exposure.
 - g. 20-44Fg/dl repeat venous level in 1 week to one month, try to identify sources of lead exposure and remove child from the environment or source from child's environment.
 - h. 45-59Fg/dl repeat venous lead level in 48 hours, try to identify sources of lead exposure and remove child from the environment or source from child's environment. Consult toxicologist for possible chelation therapy.
 - i. 60-69Fg/dl repeat venous lead level in 24 hours, try to identify sources of lead exposure and remove child from the environment or source from child's environment. Consult toxicologist for possible chelation therapy.
 - j. 70Fg/dl repeat venous lead level immediately, try to identify sources of lead exposure and remove child from the environment or source from child's environment. Consult toxicologist for possible chelation therapy.

PB-TX TREATMENTS

OUTCOME: The patient/family will have an understanding of the possible treatments that may be performed based on the test results.

STANDARDS:

1. Refer to [PB-TE](#).
2. Discuss the role of proper nutrition in treatment of lead exposure and lead toxicity. Refer to [PB-N](#).
3. Discuss as appropriate that children with blood lead level ≥ 45 Fg/dl are often candidates for chelation therapy.
4. Explain that chelation therapy for persons with lead encephalopathy can be life-saving.
5. Discuss as appropriate that chelation for persons without lead encephalopathy may prevent symptom progression and further toxicity.
6. Discuss the agent to be used for chelation in persons who are to undergo chelation. Discuss the risks and benefits of treatment.
7. Explain that the treatment decision will be made by the patient and medical team after reviewing the results of diagnostic tests.

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.

LIV – DP DISEASE PROCESS

OUTCOME: The patient/family will have an understanding of 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 adherence to 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 and 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 adherence with the treatment plan.
2. Emphasize 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 of strict adherence to 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 have an understanding of 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-TX TREATMENT

OUTCOME: The patient/family will have an understanding of 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 adherence even if the patient is asymptomatic.
4. Emphasize the importance of keeping scheduled follow-up appointments.
5. Refer to community resources as appropriate.

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 will understand the importance of exercise as a part of treatment plan.

STANDARDS:

1. Explain that moderate exercise may increase energy, improve circulation, enhance sleep, and reduce stress and depression.
2. Encourage a program of regular exercise for optimal benefit.

DEP-FU FOLLOW-UP

OUTCOME: The patient and family will understand the importance of treatment plan adherence 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-uptake blockers or psychotropic medications that work by other mechanisms.
7. Discuss the risks associated with the medications especially in overdose. 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-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.

MEDS-C COMPLICATIONS

OUTCOME: The patient and/or family will understand the importance of preventing and managing medical errors.

STANDARDS:

1. Discuss with patients/family members that it is important for them to take an active role in their health care.
2. Discuss with the patient/family how to contact the appropriate health care provider with questions regarding medical therapy or potential medical errors.
3. Discuss with the patient/family when it is appropriate to go to the emergency room if a medical error, medication side-effect, or other emergency situation occurs as a result of medical treatments.

MEDS-FU FOLLOW-UP

OUTCOME: The patient and/or family will understand the importance of maintaining follow up care.

STANDARDS:

1. Discuss the importance of maintaining follow-up appointments to minimize the risk of medical errors.
2. Discuss the importance of reviewing follow-up information such as laboratory results and other test results.

MEDS-I INFORMATION

OUTCOME: The patient/family will be able to identify their primary provider and the condition(s) for which the patient is being treated.

STANDARDS:

1. Emphasize the importance of knowing the identity of the physician in charge of the total care.
2. Assist the patient/family in identifying their primary physician.
3. Discuss the conditions for which the patient is being treated and methods of treatment being used as well as options available.
4. Refer to reliable resources for more information as appropriate.

MEDS-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient and/or family will receive written information regarding medical therapies, contact information, and health concerns.

STANDARDS:

1. Provide written information describing medications that are being prescribed/dispensed, common side effects of medications dispensed, and contact information for patients in case they experience a side effect from their medication.
2. Provide written information describing treatment plans that are being prescribed/dispensed, cautions to therapy, and contraindications to therapy.
3. Provide written information describing procedures or surgeries that are being prescribed/dispensed, cautions of therapy, and contraindications of therapy.
4. Discuss the content of written information with the patient and family.

MEDS-M MEDICATIONS

OUTCOME: The patient and family will understand that medications are a potential source for medical errors.

STANDARDS:

1. Discuss with patients/family members that it is important for them to take an active role in their health care.
2. Discuss the importance of informing providers of all medical therapies that you are taking. This includes:
 - a. Prescribed medications
 - b. Alternative therapies, i.e., traditional medicine
 - c. Herbal medications
 - d. Oral nutritional supplements, vitamins and minerals
 - e. Over-the-counter medications
3. Discuss the importance of informing your providers of any allergies or adverse medication reactions that you may have experienced.
4. Discuss the importance of being able to identify any medications that your provider has written and knowing what medications are being prescribed.
5. Discuss the importance of obtaining understandable medication information. Also ensure that directions on medication labels are clear and easily understood. Discuss that this information should be provided every time your prescription is filled.
6. Discuss the importance of having the pharmacist verify that this is the medication that was prescribed by your provider.
7. Instruct the patient to check the medication label to verify the patient's name on the medication.
8. Discuss the importance of being able to take the appropriate amount of medication. Ensure dosage forms can be obtained (i.e., breaking tablets in half or using a pill cutter) and that appropriate measuring devices (i.e., pill boxes, oral syringes, droppers) are provided and instruction on their use given.

MEDS-P PREVENTION

OUTCOME: The patient and family will understand ways to prevent medical errors.

STANDARDS:

1. Discuss the types of medical errors:
 - a. medicine
 - b. surgery
 - c. diagnosis
 - d. equipment
 - e. lab reports
2. Explain that medical errors can occur anywhere in the health care system including the hospital, clinic, outpatient surgery center, doctor's office, nursing home, pharmacy, patient's home, and referral services.
3. Discuss with patients/family members that it is important for them to take an active role in their health care.
4. Discuss the importance of knowing who the patient may contact for medical advice and information.
5. Discuss the importance of all health care workers being aware of your health and care and having your medical record available.
6. Instruct patient that if necessary, a family member or friend may accompany them to their appointment.
7. Explain that when possible, you should select a hospital that has experience in the procedures that you need.
8. Emphasize the importance of proper hand washing in the prevention of disease transmission. Encourage the patient to ask the health care worker about hand washing if there are any concerns.

MEDS-TE TESTS

OUTCOME: The patient/family will understand the importance of knowing what test(s) will be performed, why they will be performed, and how to obtain the results.

STANDARDS:

1. Explain to the patient/family the procedure of asking about tests that are ordered and the reasons for them. Emphasize the importance of knowing what tests will be done and why they will be done.
2. Explain to the patient how to obtain test results if they have not been provided.

M-DI DRUG INTERACTION

OUTCOME: The patient/family will have an awareness of potential drug, food, or alcohol interactions associated with their prescribed medications.

STANDARDS:

1. Explain the potentially serious adverse effects of the specific interactions 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 (physician, pharmacist, nurse, etc.) of any drug interaction(s) that have occurred in the past.
4. Inform the patient of the procedure to follow in the event of a drug interaction.

M-FU FOLLOW-UP

OUTCOME: The patient will demonstrate knowledge of the use and benefits of their medications in the treatment of disease process.

STANDARDS:

1. Review name of medication and reason for use. Show medication to patient where applicable.
2. Ask patient to explain how medications are to be taken at home.
3. Review possible adverse drug reactions, importance for adherence, and benefits of therapy.

M-I INFORMATION

OUTCOME: The patient/family will have a general understanding of the use and benefits of the medications prescribed.

STANDARDS:

1. Give the name of the drug and show drug to patient where applicable.
2. Briefly review the mechanism of action of the drug.
3. Review directions for use and duration of therapy.
4. Discuss probable benefits of therapy.
5. Discuss importance of adherence with medication regimen.
6. Review probable side-effects and toxicities of medication. Review the course of action to take if toxicity occurs.
7. Emphasize the importance of informing the provider prior to initiating any new medications.
8. Discuss the proper storage and handling of medications.

M-L PATIENT INFORMATION LITERATURE

OUTCOME: Patient/family will receive written information about medication(s) prescribed.

STANDARDS:

1. Provide patient/family with written patient information literature about the prescribed medication(s).
2. Discuss the content of the patient information literature with the patient/family.

M-PRX MEDICATION DISPENSATION TO PROXY

OUTCOME: The person to whom the medication is dispensed will understand information about the medication and develop a plan to assure proper medication use.

STANDARDS:

1. The proxy will receive information on proper administration of the medications dispensed.

MPS-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the anatomy and physiology of the female reproductive system and the changes associated with menopause.

STANDARDS:

1. Explain the normal anatomy and physiology of the female reproductive system.
2. Explain that hormones produced by the ovaries have wide ranging effects that involve not only the uterus and ovaries but also the brain, skin, blood vessels, heart, bones, breasts, and the urinary system.
3. Explain that menopause is a normal part of life and involves changes in levels of many hormones as well as physical and emotional changes.

MPS-C COMPLICATIONS

OUTCOME: The patient/family will understand some of the potential changes associated with menopause.

STANDARDS:

1. Discuss the changes that may occur with menopause and the impact of these changes on the patient's health. Explain how complications/symptoms of menopause are related to decreased estrogen and other hormones.
 - a. Loss of bone density leading to osteoporosis may include oral cavity changes
 - b. Increased cardiovascular risks
 - c. Loss of fertility
 - d. Vasomotor symptoms, hot flashes
 - e. Mood changes (Irritability, anxiety, mood swings, depression, agitation, changes in libido) and sleep disturbances
 - f. Urogenital symptoms: atrophy, thinning, dryness, vulvar itching/irritation, loss of vaginal elasticity, pain/discomfort with sexual activity, frequent urination, urinary urgency, stress incontinence, pelvic relaxation
 - g. Mild concentration and memory impairment
 - h. Ocular changes (dryness, burning, pressure, sensitivity to light, blurred vision, increased lacrimation)
 - i. Weight gain, palpitations, skin changes, joint pain, and headache
 - j. Hair changes

MPS-DP DISEASE PROCESS

OUTCOME: The patient/family will have an understanding of the changes that may occur with menopause.

STANDARDS:

1. Discuss menopause as the end of menstruation and fertility usually defined by no menstruation for 12 months. Explain that menopause may be caused by medical interventions, such as surgery, chemotherapy, or pelvic radiation but more commonly menopause occurs as a result of a normal developmental process.
2. Explain that in the United States menopause typically occurs between 45-55 years of age but may occur earlier or later. The whole process may take several months or years.
3. Discuss common manifestations of menopause:
 - a. Vasomotor: hotflashes may include irritability, anxiety, sleeplessness, and agitation
 - b. Urogenital: atrophy, thinning, dryness, and loss of elasticity.
4. Discuss the different classifications of menopause:
 - a. Age 45-55 with hot flashes and irregular menses assume perimenopausal
 - b. Age 45-55 with hot flashes and no menses for 6 months assume menopausal
 - c. Age < 45 with hot flashes but regular menses or irregular menses but no hot flashes could be early menopause further investigation may be indicated
 - d. Age 40-50 Menopausal symptoms still on oral contraceptives possibly menopause further investigation may be indicated.
5. Discuss how menopause relates to altered hormone production. As appropriate discuss the current understanding of medications/herbals/etc in the treatment of menopausal changes.

MPS-EX EXERCISE

OUTCOME: The patient/family will have an understanding of the relationship between exercise and the changes of menopause and will develop a plan to achieve an appropriate activity level.

STANDARDS:

1. Explain the benefits of regular exercise. Consult a physician or health care provider before beginning an exercise program.
2. Explain the particular relevance of exercise to menopausal changes such as weight gain, depression, and decreased bone density.
3. Review activity recommendations including:
 - a. Weight bearing exercise (e.g. walking, dancing, bowling, tennis, basketball, volleyball, soccer, using hand weights)
 - b. Exercise involving many muscle groups
 - c. Repetitive use of muscle groups to maintain or preserve bone mass
 - d. Importance of sustained exercise for 30 minutes at least five times per week.
4. Assist patient and family in developing an appropriate physical activity plan.
5. Refer to community resources as appropriate.

MPS-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.

MPS-L LITERATURE

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

STANDARDS:

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

MPS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand that certain behaviors reduce the risk of complications that may be associated with menopausal changes.

STANDARDS:

1. Discuss behaviors which promote good health and reduce the risk of potential complications associated with menopausal changes, i.e., osteoporosis and cardiovascular disease including:
 - a. Avoidance of tobacco, excessive caffeine, and other drugs of abuse
 - b. Regular weight bearing exercise to reduce the risk of osteoporosis and regular aerobic exercise to reduce the risk of cardiovascular disease
 - c. Stress reduction
 - d. Balanced diet low in fat and rich in calcium and Vitamin D
 - e. Maintaining a healthy weight.
3. Advise the patient of potential triggers for hot flashes and avoidance of triggers:
 - a. Stress and anxiety
 - b. Spicy foods
 - c. Caffeine
 - d. Hot drinks
 - e. Alcoholic beverages
 - f. Hot environment.
4. Discuss the current recommendations for breast exams including mammography. Refer the patient to a physician for the most current information.

MPS-M MEDICATIONS

OUTCOME: The patient/family will understand the role of medications in the treatment of menopausal changes and complications including benefits and risks of treatment.

STANDARDS:

1. Review the medication(s) with the patient. 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 the medications. Review common and important drug/drug, drug/food reactions.
3. Emphasize adherence to the medication plan and explain how effective use of medications may reduce complications.

MPS-N NUTRITION

OUTCOME: The patient/family will understand the importance of healthy food choices and plan for dietary modifications as needed.

STANDARDS:

1. Discuss changes of menopause that may be addressed by dietary modifications including:
 - a. Weight gain
 - b. Cardiovascular changes
 - c. Decreased bone density.
2. Discuss optimal nutrition
 - a. Appropriate caloric intake in response to metabolic changes associated with aging
 - b. Maintain adequate intake of calcium and vitamin D through diet and supplements as needed.
3. Refer to registered dietician, physician or pharmacist as appropriate discuss other dietary modifications or supplements/herbals.

MPS-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure, including indications, complications, and alternatives, as well as possible results of not having the procedure performed.

STANDARDS:

1. Discuss the indications, risks, and benefits for the proposed procedures such as pap smears, mammograms, and endometrial monitoring (transvaginal ultrasound, endometrial biopsy).
2. Explain the process and what to expect before, during, and after the procedure.
3. Discuss pain management as appropriate.
4. Emphasize the importance of adherence to post-procedure recommendations and follow-up.
5. Discuss procedure findings and implications as appropriate.

MPS-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand principles of injury prevention associated with osteoporosis.

STANDARDS:

1. Discuss ways to reduce risk of falls. Adapt home safety to prevent injury including removing throw rugs, install bars in the tubs and showers, secure electrical cords. **Refer to [OS](#) and [FALL](#).**
2. Identify community resources that promote safety and injury prevention.
3. Provide information regarding key concepts for emergencies.

MH-BE BREAST EXAM

OUTCOME: The patient/family will understand the importance of breast self-exam and clinical breast exam on physicals.

STANDARDS:

1. Discuss breast anatomy and that cancer can occur in males as well as in females.
2. Emphasize the importance of examination for early detection of breast cancer.
3. Explain that survival rates are markedly higher when cancer is detected and treated early.
4. Teach breast self-exam. Participate in return demonstration.
5. Discuss the importance of routine annual clinical examination.

MH-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.

MH-HY HYGIENE

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

STANDARDS:

1. Review aspects of good hygiene such as regular bathing, paying special attention to penis and glans.
2. Refer to [WL-HY](#).

MH-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about men's health issue.

STANDARDS:

1. Provide the patient/family with written patient information literature on men's health issue.
2. Discuss the content of the patient information literature with the patient/family.

MH-M MEDICATIONS

OUTCOMES: 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 strict adherence to the medication regimen and monitoring schedule.
3. Instruct patient on proper administration of the drug.

MH-PRS PROSTATE HEALTH

OUTCOME: The patient will understand the importance of prostate health and cancer prevention.

STANDARDS:

1. Discuss the prostate and the normal changes that occur with age.
2. Discuss the prostate exam and emphasize the importance of examination in early detection of prostate cancer. Explain that survival rates are markedly higher when cancer is detected and treated early.
3. Explain that patients who have first-degree relatives with prostate cancer are at significantly higher risk for cancer.
4. Emphasize the importance of follow-up exams.
5. Discuss the role of prostate-specific antigen testing in the early detection of prostate cancer.

MH-RS REPRODUCTIVE SYSTEM

OUTCOME: The patient will understand the male reproductive system.

STANDARDS:

1. Review the reproductive anatomy and physiology of the male reproductive system.
2. Discuss pathways for sperm during ejaculation.
3. Discuss the importance of good hygiene. Discuss circumcision as appropriate.
4. Discuss prevention and treatment of sexually transmitted diseases. **Refer to [STD](#).**

MH-TSE TESTICULAR SELF-EXAM

OUTCOME: The patient will understand the importance of routine testicular self exam.

STANDARDS:

1. Explain that the purpose of the TSE is to screen for abnormal signs and symptoms of the testes.
2. Emphasize the importance of routine two-step basic TSE. Encourage patients to associate the TSE routine with an important monthly date.

MSX-C COMPLICATIONS

OUTCOME: The patient will have an understanding of 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-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 such as stores, etc.
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 exercise goal is at least 30 minutes of aerobic activity most days of the week.
3. Encourage the patient to begin exercise at a comfortable level and increase the frequency, intensity and duration of the activity as she/he becomes fit. Refer the patient to a physician for evaluation prior to beginning an exercise program as appropriate.
4. Assist the patient in developing a personal exercise plan. **Refer to [WL-EX](#).**
5. Discuss the potential obstacles to a personal exercise plan and solutions to these obstacles.

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 have an understanding of their medication(s), regimen and the importance of adherence to 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 have an understanding of the importance of nutritional management in the improvement of metabolic syndrome.

STANDARDS:

1. Refer to 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-TE TESTS

OUTCOMES: The patient will have an understanding of the test(s) to be performed including indications and its impact on further care.

STANDARDS:

1. Explain the test(s) ordered (FBS , A1C, Lipids, etc.).
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.
5. Explain the test as it relates to planning the course of treatment.

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-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 are any place one can reasonably anticipate seeing more than 4 or 5 people, such as grocery stores, department stores, ball games, school functions, restaurants, etc.)
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 breast milk.)
6. Explain that breastfeeding improves the neonates immune system by the passing of antibodies to the infant in the mother's milk.

NF-TE TESTING

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.

ND-DP DISEASE PROCESS

OUTCOME: The patient and/or family members will understand the patient's neurological disease process.

STANDARDS:

1. Review the anatomy and physiology of the nervous system as it relates to the patient's disease process and its relationship to the patient's activities of daily living.
2. Discuss the pathophysiology of the patient's neurological disorder and how it may affect function and lifestyle.

ND-EQ EQUIPMENT

OUTCOME: The patient/family will verbalize understanding 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 safe use of equipment.

ND-EX EXERCISE

OUTCOME: The patient and/or family members will understand the importance of exercise in enhancing physical and psychological well-being.

STANDARDS:

1. Review the prescribed treatment plan.
2. Explain the hazards of immobility. Discuss how to prevent decubitus ulcers, contractures, constipation, renal calculi, isolation and a loss of self-esteem.
3. Emphasize that physical activity/therapy is an integral part of the patient's daily routine. Make referrals as indicated.

ND-FU FOLLOW-UP

OUTCOME: The patient and /or family members 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, social services, physical therapy, mental health services, nutritionist and community health services.
2. Assess the need for any additional follow-up and make the necessary referrals.

ND-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

ND-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient and/or family members will understand what lifestyle adaptations are necessary to cope with the patient's specific neurological disorder.

STANDARDS:

1. Assess the patient's and family's level of acceptance of the disorder.
2. Refer to Social Services, Mental Health, Physical Therapy, Rehabilitative Services, and/or community resources as appropriate.
3. Review the lifestyle areas that may require adaptations: diet, physical activity, sexual activity, bladder/bowel habits, role changes, communication skills and interpersonal relationships.
4. Refer to occupational therapy as indicated for assistance with activities of daily living.

ND-M MEDICATIONS

OUTCOME: The patient and/or family members will understand the goals of drug therapy, the side effects of the medications and the importance of medication adherence.

STANDARDS:

1. Review mechanisms of action for 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 medication adherence.

ND-N NUTRITION

OUTCOME: The patient and/or family members will understand what dietary modification may be necessary for a patient with a neurological disorder.

STANDARDS:

1. Review the feeding technique appropriate for the patient.
2. Identify problems associated with feeding a neurologically impaired patient:
 - a. Motor impairment: Feeding may take more time, swallowing may be difficult and aspiration is a risk.
 - b. Sensory impairment: Loss of taste. Inability to sense temperature may result in burns.
3. Consider referral to Social Services for help in obtaining equipment and home health services.

ND-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that neuropathic pain may be significant and needs to be discussed with the medical provider.
2. Explain that the use of over the counter medications for chronic pain management needs to be assessed by the medical provider to minimize risk to kidney function.
3. Explain that all chest pain must be evaluated by the medical provider to rule out the possibility of myocardial infarction.

ND-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

1. Explain to patient and 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 (remove throw rugs, install bars in tub/shower, secure electrical cords, etc.).
3. Stress importance and proper use of mobility devices (cane, walker, wheel chair).

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-DP DISEASE PROCESS

OUTCOME: The patient and 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. Refer to [WL-EX](#).

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 (fad diets, surgery, medications, etc.).

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 (physician, pharmacist, nurse, etc.) 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 and 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.

ODM-C COMPLICATIONS

OUTCOME: The patient will understand the ocular complications of diabetes.

STANDARDS:

1. Explain the long-term ocular effects of the condition. Emphasize that the outcome depends upon the patient's control of diabetes.
2. Discuss the symptoms indicative of progression of ocular diabetes.

ODM-DP DISEASE PROCESS

OUTCOME: The patient will understand and verbally summarize how diabetes can affect the health of their eyes and their vision.

STANDARDS:

1. Review the current information regarding ocular diabetes. Explain that diabetic retinopathy is a result of retinal ischemia and edema which can result in visual loss or total blindness.
2. Explain that the ocular complications of DM result from high blood sugar and that good control of blood sugar helps prevent loss of vision.
3. Explain that high blood sugar levels can cause swelling of the lens of the eye which can result in blurred vision which may resolve when the blood sugar is under good control.
4. Help the patient develop a plan to achieve diabetes control. Refer to other departments or agencies as appropriate.

ODM-FU FOLLOW-UP

OUTCOME: The patient will understand his/her responsibility to make and keep follow-up appointments in order to maintain optimal ocular health.

STANDARDS:

1. Discuss the status of the ocular condition and the potential to maintain, lose, or regain visual capabilities.
2. Discuss available interventions to help the patient maintain visual capability as much as possible.
3. Discuss the importance of annual dilated eye exams in detecting diabetic retinopathy at an early stage where treatment is most likely to be effective.

ODM-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

ODM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the relationship between elevated blood sugar and loss of vision and will develop a plan to achieve and maintain good blood sugar control.

STANDARDS:

1. Emphasize the importance of diet and weight-control guidelines as they relate to blood sugar control and ocular health. **Refer to [DM-LA](#).**
2. Explain that use of tobacco products can exacerbate the disease process and lead to increased loss of vision.
3. Help the patient develop a plan to control blood sugar. Refer to local resources as appropriate.

ODM-LT LASER THERAPY

OUTCOME: The patient will understand the procedure, benefits, and common risks of laser therapy.

STANDARDS:

1. Explain the proposed procedure and indications for the procedure as it relates to the patient's condition.
2. Discuss the common and/or important risks and the potential benefits of the proposed procedure. Explain that the therapy prevents worsening of the condition but probably will not restore any lost vision.
3. Explain the preparation for the procedure.

ODM-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 strict adherence to the medication regimen and monitoring schedule.
3. Instruct patient on proper administration and storage of the drug.

ODM-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand that pain relief may be available.

STANDARDS:

1. Discuss the pain management options which are available.
2. Help the patient develop a plan to monitor and manage pain.
3. Discuss symptoms which should prompt an evaluation such as increasing pain unresponsive to the usual measures.

OS-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of untreated or progressed osteoporosis.

STANDARDS:

1. Explain that the most common complication of untreated or progressed osteoporosis is fracture.
2. Explain that spinal compression fractures are common and result in back pain and the typical "buffalo hump" often seen in elderly patients.
3. Explain that fractures of the long bones including fractures of the hip are not uncommon and may be debilitating.
4. Explain that pain (especially early morning low back pain) may be a symptom of osteoporosis even in the absence of demonstrable fractures. This can be mistaken for arthritis.
5. Explain that osteoporosis may cause tooth loss secondary to gingival bone loss. Stress the importance of good oral hygiene.

OS-DP DISEASE PROCESS

OUTCOME: The patient will verbalize understanding of the causes and symptoms of osteoporosis.

STANDARDS:

1. Explain that humans reach their peak bone mass at about 30. After age 30 progressive bone loss typically occurs.
2. Explain that bone loss may be slowed by consistent daily exercise and appropriate calcium intake. **Refer to [OS-N](#).**
3. Explain that medication, calcium supplementation and hormonal replacement therapies may be helpful in selected cases.
4. State that progressive bone loss may result in fractures and/or pain. **Refer to [OS-C](#).**
5. Discuss risk factors for earlier onset or more severe osteoporosis, such as petite frame, sedentary lifestyle, smoking, inadequate calcium intake, caffeine intake.
6. Discuss the current state of understanding about the role of estrogen and other hormones as they relate to osteoporosis.

OS-EX EXERCISE

OUTCOME: The patient/family will have an understanding of the importance of weight bearing exercise in delaying bone loss and will make a plan for reasonable exercise.

STANDARDS:

1. Explain that exercise decreases bone loss by repetitive use of muscle groups. This repetitive use of muscles causes stress on the bones resulting in build-up of bone mass.
2. Explain that exercises involving weight bearing and many muscle groups are more beneficial than non weight bearing exercises. Some examples of weight bearing exercises are walking, dancing, bowling, tennis, basketball, volleyball, soccer, and for elderly patients using hand-held weights.

OS-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of adherence to treatment regimen and make a plan for appropriate follow-up.

STANDARDS:

1. Discuss the individual's responsibility in the management of osteoporosis.
2. Review the treatment plan with the patient, emphasizing the importance for follow-up care.
3. Discuss the procedure for obtaining follow-up appointments.

OS-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management plan needed to maintain function and optimal health.

STANDARDS:

1. Review the lifestyle areas that may require adaptation - diet, exercise, etc.
2. Stress the importance of a calcium rich diet, regular weight-bearing exercise, decreased stress, not smoking, reduced alcohol intake and estrogen replacement therapy as appropriate.
3. Explain to the patient/family members the importance of body mechanics and proper lifting techniques to avoid injury.
4. Assist family/patient to identify ways to adapt the home to improve safety and prevent injury (remove throw rugs, install bars in tubs and showers, secure electrical cords, etc.).

OS-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

OS-M MEDICATION

OUTCOME: The patient/family will understand the medications to be used in the management of osteoporosis.

STANDARDS:

1. Discuss the current knowledge about the correct amount of calcium intake for a patient of this age. Discuss ways of obtaining calcium: supplements, dietary intake, calcium based antacids, etc.
 - a. As of 5/2000 the following are believed to be the correct calcium needs for various age groups:
 - i. 7-9 years old 700 mg
 - ii. 10-12 years old 1000-1400 mg
 - iii. 13-16 years old 1200-1400 mg
 - iv. 19-49 years old 1000 mg
 - v. 50+ years old 1000-1500 mg
2. Explain that Vitamin D improves calcium absorption.
3. Discuss ways to get vitamin D: supplementation, sunlight exposure, etc., (as of 5.2000 the correct amount of Vitamin D thought to be needed is 400 IU per day.).
4. Discuss the use of estrogen to prevent osteoporosis if appropriate. Discuss potential adverse effects of estrogen as well as the potential benefit.
5. Discuss the use of SERMS (Selective Estrogen Receptor Modifiers) in the prevention and sometimes regression of osteoporosis. Discuss common and important side-effects of the medications.
6. Discuss other medications sometimes used in the treatment of osteoporosis, e.g. Calcitonin, and biphosphonates as appropriate.
7. Discuss the medications to be prescribed for the patient, the proper use, storage, dosage, important and common side-effects.
8. Discuss medications which may increase the risk for osteoporosis such as thiazide diuretics, magnesium, steroid medications etc.

OS-N NUTRITION

OUTCOME: The patient/family will verbalize understanding of ways to treat osteoporosis by nutritional therapy.

STANDARDS:

1. Discuss that appropriate intake of calcium will reduce the risk of developing osteoporosis and therefore reduce the risk of fracture.
2. Discuss foods high in calcium like all dairy products, some greens like turnip greens, kale, broccoli, collard greens and mustard greens, fish with bones like sardines, and salmon and calcium fortified foods, juices and beverages.
3. Discuss that greens are not as good a source of calcium as they do not contain Vitamin D which is essential to good absorption of calcium.
4. Explain that some greens, like spinach, beet greens and rhubarb, contain a substance (oxalate) which inhibits the absorption of calcium and are not a good source of calcium even though they do contain calcium.
5. Explain that dairy products are an excellent source of calcium and that the fat content of milk has nothing to do with the calcium content.
6. Explain that the body requires a balance of phosphorus and calcium. Carbonated beverages contain an excess of phosphorus and may result in an overall loss of calcium from the body.
7. Explain that caffeine, sodium and excessive amount of protein may result in calcium loss for the body.

OS-P PREVENTION

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

STANDARDS:

1. Explain that peak bone mass is achieved by age 30. A higher peak bone mass will result in a higher starting place when bone mass begins to decrease after age 30.
2. Explain how regular exercise increases bone mass thereby reducing the risk of osteoporosis. Regular exercise after age 30 will decrease the rate of bone loss and in some cases reverse bone loss.
3. Explain that daily intake of calcium will help prevent bone loss and if adequate calcium intake is accomplished in childhood and adolescence there will be a larger peak bone mass.
4. Explain the current knowledge about appropriate intake of calcium for various age levels.
5. Assist the patient/family in development of a plan to prevent osteoporosis.

OS-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of 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 non-pharmacologic measures that may be helpful with pain control.

OS-TE TESTS

OUTCOME: The patient/family will understand the proposed test(s) to be performed and the expected benefit and potential risk of the test(s) as well as the risks of not testing.

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.

OS-TX TREATMENT

OUTCOME: The patient will verbalize understanding of the treatment plan.

STANDARDS:

1. Explain that the major treatment for osteoporosis is exercise and appropriate intake of calcium and Vitamin D.
2. Explain that some patient will require other medications in addition to the above mentioned treatment. **Refer to [OS-M](#).**

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.

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.

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. (Warm packs, etc.)

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 (rubbing, stroking, touching, etc.) may block the brain's reception of pain signals.

PM-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pain symptoms, type (chronic, acute, malignant, etc.) 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-EX EXERCISE

OUTCOME: The patient will understand the importance of exercise as a part of the pain management treatment plan.

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. Encourage a program of regular exercise for optimal benefit.

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 (familial, traditional, cultural, etc.) 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 adherence 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 and 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 adherence 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 adherence to 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, adherence 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 such as support groups, individual therapy, family counseling, spiritual counseling, etc. Refer as appropriate.

PM-TE TESTS

OUTCOME: The patient and family will have an understanding of the tests to be performed.

STANDARDS:

1. Explain the test ordered (EMG, CT scan, ultrasound, etc.).
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 have an understanding of 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-DP DISEASE PROCESS

OUTCOME: The patient will verbalize understanding of 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 (steady, boring pain radiating to the back or shoulder; low-grade fever; bulky, pale, foul-smelling stools; nausea and/or vomiting; abdominal distention, jaundice, etc.).
3. Relate some common causes (alcohol ingestion, biliary tract disease, postoperative, post-trauma, metabolic conditions, infections, drug-associated, connective tissue disorders with vasculitis, etc.).

PC-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of adherence to 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 strict adherence to the medication regimen and monitoring schedule.
3. Instruct patient on proper administration of the drug.

PC-N NUTRITION

OUTCOME: The patient will verbalize understanding of 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 nutritionist as appropriate.

PC-P PREVENTION

OUTCOME: The patient will be able to identify factors related to pancreatitis and if appropriate verbalize 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 have an understanding of 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-TX TREATMENT

OUTCOME: The patient will verbalize understanding of 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-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-DP DISEASE PROCESS

OUTCOME: The patient and significant others(s) will verbalize understanding of 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 etc.
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 verbalize understanding of 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 (pregnancy of a friend or family member, holidays etc.) 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 verbalize understanding of 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 strict adherence to 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-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.

PD-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the supportive structures of the tooth.

STANDARDS:

1. Discuss the importance of the supportive structures of the tooth which are composed of attached tissue, periodontal ligaments and alveolar bone.

PD-C COMPLICATIONS

OUTCOME: The patient/family will understand some of the complications of periodontal disease.

STANDARDS:

1. Discuss that periodontal disease may cause seeding of the blood with bacteria. Some of the complications of this may be:
 - a. Valvular heart disease
 - b. Myocardial infarction
 - c. Stroke
 - d. Low birth-weight infants
 - e. Pre-term delivery
2. Discuss that periodontal disease often results in loss of alveolar bone and loosening of teeth. This may eventually result in tooth loss.
3. Discuss that periodontal disease almost always results in bad breath.
4. Discuss that periodontal disease may result in dental caries. **Refer to [DC](#).**

PD-DP DISEASE PROCESS

OUTCOME: The patient/family will be able to understand the periodontal disease process and list some of the causes.

STANDARDS:

1. Explain that bacterial plaque release toxins that irritate and damage the gums. Over time this infectious process may progress to involve the supporting structures of the tooth leading to bone loss and eventual loss of the tooth/teeth.
2. Explain that genetics and lifestyle choices play a role in the development of periodontal disease, i.e., diseases of the immune system, uncontrolled diabetes, and tobacco and/or alcohol use.
3. Explain that early seeding of the mouth with pathologic bacteria may predispose to the development of periodontal disease.

PD-FU FOLLOW-UP

OUTCOME: The patient will verbalize understanding of the importance of regular dental follow-up.

STANDARDS:

1. Explain the course of treatment for the current disease process, including the schedule for treatments and follow-up.
2. Emphasize the importance of following the current recommendations for routine dental examination and periodontal maintenance appointments.
3. Emphasize the importance of a dental visit if any problems occur between scheduled dental visits.
4. Assist the patient in making follow-up appointments and refer to outside providers as appropriate.

PD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about periodontal disease, its treatment and/or the oral care necessary for prevention/maintenance of disease.

STANDARDS:

1. Provide patient/family with written patient information literature on periodontal disease, treatment and/or the oral care necessary for prevention/maintenance of disease.
2. Discuss the content of the patient information literature with the patient/family.

PD-M MEDICATIONS

OUTCOME: The patient/family will understand the importance of medication in the treatment of the periodontal disease and make a plan to comply 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. Discuss the use of chlorhexidine as appropriate. Discuss the common and important side-effects, common or important drug interactions (i.e., fluoride) and indications for immediate follow-up.
3. Explain the importance of completing the course of therapy and its role in eradicating the infection and/or decreasing the infectiousness of the periodontal disease.
4. Explain, as appropriate, that failure to complete the course of antibiotics may cause the development of resistant organisms.
5. Discuss, as appropriate, the concomitant use of antipyretics or NSAIDs.

PD-N NUTRITION

OUTCOME: The patient/family will understand the importance of a balanced diet, low in carbohydrates, especially simple sugars, and with adequate calcium and fluoride.

STANDARDS:

1. Discuss the relationship between a diet high in carbohydrates, especially simple sugars, to the development of dental caries. Give examples of foods high in simple sugars, i.e., crackers, potato chips, candy, pre-sweetened cereals.
2. Discuss the importance of calcium and fluoride intake as it relates to tooth development/mineralization.
3. Discuss foods that may be contraindicated secondary to instability of the teeth, i.e., apples, corn on the cob.
4. Refer to a dietician as appropriate.

PD-P PREVENTION

OUTCOME: The patient will be able to identify some ways to help prevent periodontal disease.

STANDARDS:

1. Early entry (prenatal and infancy) into dental care is important in the prevention of periodontal disease.
2. Emphasize the importance of treating all family members with periodontal disease, especially if the family includes children ages 6 months to 8 years.
3. Explain that the best preventive measures are daily plaque removal, primarily by brushing and flossing.
4. Emphasize the importance of regular and timely dental examination and professional cleaning in the prevention of periodontal disease.

PD-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of 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 Tylenol, NSAIDS, and/or narcotics may be helpful in pain management as appropriate.
3. Explain that antibiotics may be helpful in pain relief.
4. Explain non-pharmacologic measures that may be helpful with pain control, i.e., avoid firm foods.
5. Explain that dental anxiety may be controlled or relieved by the use of anxiolytics or antihistamines as appropriate.
6. Explain that local anesthetics and/or nitrous oxide may be used to control pain during dental procedures.

PD-TE TESTS

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

STANDARDS:

1. Discuss the test(s) to be performed, i.e., x-ray, bacteriological testing, periodontal probing.
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.

PD-TX TREATMENT

OUTCOME: The patient will verbalize understanding of the necessary treatment (scaling and root planning, chemotherapeutics, surgical treatment, etc.) and the proper oral care after treatment.

STANDARDS:

1. Explain the proposed procedure including indications, risks, benefits, alternatives and the consequences of non-treatment.
2. Review the specific elements of periodontal maintenance after treatment, i.e., daily plaque removal, use of oral rinses, and keeping scheduled appointments.

PVD-C COMPLICATIONS

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

STANDARDS:

1. Discuss common and important complications of PVD, i.e., injury, infection, amputation.
2. Emphasize early medical intervention for any injury, increased pain, decreased sensation, or signs/symptoms of infection (pain, redness, warmth).

PVD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of PVD.

STANDARDS:

1. Explain that PVD is the result of the buildup of plaque in the interior walls of the vessels supplying the extremities.
2. Explain that PVD is a chronic, progressive, and treatable disease.
3. Review the factors related to the development and progression of PVD (tobacco use, HTN, DM, obesity, and hyperlipidemia). Emphasize the patients with PVD are at greatly increased risk for other vascular diseases (CAD, CVA).
4. Review the symptoms of PVD (pain in extremities during exercise, coolness of hands and/or feet, ulcers of the extremities, skin pallor).

PVD-FU FOLLOW-UP

OUTCOME: The patient will verbalize an understanding of the importance of adhering to a treatment regimen, be able to identify appropriate actions to take for symptoms indicating life- or limb-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 peripheral vascular disease.
2. Review treatment plan with the patient, emphasizing the need for keeping appointments, complying with medication therapy, adhering to dietary modifications, and maintaining an appropriate activity/rest balance.
3. Review the symptoms which should be reported and evaluated (symptoms more frequent or occurring during rest, symptoms lasting longer, etc.).

PVD-HM HOME MANAGEMENT

OUTCOME: The patient/family will have an understanding of the lifestyle adaptations necessary to maintain optimal health.

STANDARDS:

1. Emphasize that the most important component of home management in the prevention and treatment of peripheral vascular disease is the patient's adaptation to a healthier, lower risk lifestyle.
2. Discuss lifestyle adaptations that may reduce further risk of peripheral vascular disease and improve the quality of life (cease 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).

PVD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about peripheral vascular disease.

STANDARDS:

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

PVD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will have an understanding of the lifestyle adaptations necessary to maintain optimal health.

STANDARDS:

1. Emphasize that the most important component in the prevention and treatment of peripheral vascular disease is the patient's adaptation to a healthier, lower risk lifestyle.
2. Discuss lifestyle adaptations that may reduce further risk of peripheral vascular disease and improve the quality of life (cease 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).

PVD-M MEDICATIONS

OUTCOME: The patient will have an understanding of 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 adherence to the medication regimen.

PVD-N NUTRITION

OUTCOME: The patient/family will have an understanding of how to control peripheral vascular disease through weight control and diet modification and develop on appropriate plan for dietary modification.

STANDARDS:

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

PVD-P PREVENTION

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

STANDARDS:

1. Discuss that prevention of peripheral vascular disease is far better than controlling the disease after it has developed.
2. Explain that consuming a diet low in fat, and controlling weight and blood pressure will help to prevent PVD.
3. Discuss that persons with uncontrolled diabetes and uncontrolled hypertension are more likely to develop PVD. Stress the importance of controlling these disease processes. **Refer to [DM](#) and [HTN](#).**

PVD-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of 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.

PVD-TE TESTS

OUTCOME: The patient/family will have an understanding of the tests to be performed.

STANDARDS:

1. Explain the test ordered (Doppler ultrasound, angiography).
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.

PVD-TX TREATMENTS

OUTCOME: The patient/family will have an understanding of 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 peripheral artery blockage (angioplasty, arterial bypass, etc.).
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 the diagnostic tests.

PT-EQ EQUIPMENT

OUTCOME: The patient/family will verbalize understanding and demonstrate as appropriate proper use of equipment.

STANDARDS:

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

PT-EX EXERCISE

OUTCOME: The patient/family will relate exercise program to optimal health and plan to follow the customized exercise program developed with the Physical Therapist.

STANDARDS:

1. Review the benefits of regular exercise.
2. Discuss the three types of exercise: aerobic, flexibility, and endurance, as appropriate.
3. Review the recommendations of an exercise program:
 - a. Start out slowly.
 - b. Modification of exercises to accommodate specific health problems.
 - c. Exercise according to the specific plan developed for the individual.
4. Discuss the exercise(s) in the customized program.
5. As appropriate, demonstrate and assist in practicing the exercise(s) in the program.
6. Emphasize the importance of following the customized exercise plan developed with the Physical Therapist to achieve optimal benefit.
7. Review the exercise programs available in the community.

PT-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of complying with the treatment plan and the process for obtaining follow-up appointments.

STANDARDS:

1. Discuss the patient's responsibility in the management of his/her condition.
2. Emphasize the importance of making and keeping appropriate follow-up appointments.
3. Discuss the process for obtaining follow-up appointments.

PT-GT GAIT TRAINING

OUTCOME: The patient will verbalize understanding of the importance of improved gait and plan to practice.

STANDARDS:

1. Discuss the components necessary for optimal gait:
 - a. Normal range of motion
 - b. Proper cadence or rhythm
 - c. Appropriate stride length
 - d. Heel-to-toe pattern to step
2. Discuss the importance of normal range of motion as appropriate. Demonstrate and assist in return demonstrations of specific exercises to increase the range of motion of the affected joint(s) or extremity(s).
3. Discuss the value of cadence or rhythm in walking as appropriate. Demonstrate and assist to accomplish an improved cadence.
4. Discuss stride length as appropriate. Demonstrate appropriate stride length and assist in improving stride.
5. Discuss and demonstrate the usual heel-to-toe pattern of a normal step as appropriate. Assist the patient to learn modification techniques.
6. Emphasize the importance of intentionally practicing improved gait.

PT-I INFORMATION

OUTCOME: The patient/family will have an understanding of their physical condition as it relates to their disease process and the rehabilitative process.

STANDARDS:

1. Review the current information about the patient's specific diagnosis.
2. Review the effects that this condition has on the patient's physical status. Emphasize the short/long term effects and the degree of control that the patient has over the condition.
3. Discuss the symptoms which may indicate progression of the condition.

PT-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the physical therapy plan.

STANDARDS:

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

PT-N NUTRITION

OUTCOME: The patient will verbalize understanding of 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 condition.
4. Emphasize the importance of adherence to the prescribed nutritional plan.

PT-TX TREATMENT

OUTCOME: The patient/family will have an understanding of the common and important risks, anticipated benefits and anticipated progress of the patient's rehabilitation process.

STANDARDS:

1. Review the current information regarding the treatment of the condition.
2. Explain the benefits of the proposed treatment.
3. Assist the patient/family in development of a treatment plan which will achieve treatment goals.
4. Refer to other departments or community resources as appropriate.

PT-WC WOUND CARE

OUTCOME: The patient/family will verbalize understanding of 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; decreased infection rate, improved healing, etc.
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.

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-DP DISEASE PROCESS

OUTCOME: The patient will have an understanding of 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.

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 verbalize understanding of 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, etc.
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 have an understanding of 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 have an understanding of the appropriate treatment for pneumonia and the importance of complying 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-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 devices 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 performed, 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](#).**

PP-C COMPLICATIONS

OUTCOME: The patient and family will understand how to prevent and identify complications of the puerperium.

STANDARDS:

1. Discuss the etiology of blood clots, bleeding and infection in the postpartum period.
2. Discuss methods for prevention of complications.
3. Stress to the patient that she should seek medical care immediately for excessive bleeding, increasing abdominal pain, fever, or leg pain.

PP-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.

PP-I INFORMATION

OUTCOME: The patient will understand postpartum changes.

STANDARDS:

1. Discuss the physical changes: lochia, after-pains, breast engorgement (breast-feeding or not), weight loss, hair loss, and fatigue.
2. Discuss the common postpartum emotional changes. Encourage the patient to share her feelings with her partner, family, PHN or mental health worker.
3. Discuss the changes in interpersonal relationships and family dynamics. Identify stresses that can occur with a new family member in the household. Encourage patient to “take time for herself.”
4. Emphasize the importance of parent-child bonding.
5. Discuss the importance of a healthy lifestyle. **Refer to [WL](#).**
6. Discuss options for contraception. **Refer to [FP](#).**

PP-KE KEGEL EXERCISE

OUTCOME: The patient will understand how to use Kegel exercises to prevent urinary stress incontinence.

STANDARDS:

1. Refer to [WH-KE](#).

PP-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

PP- 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 strict adherence to the medication regimen and monitoring schedule.
3. Instruct patient on proper administration of the drug.

PP-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand some methods for treating the pain which may be associated with the postpartum period.

STANDARDS:

1. Discuss as applicable the proper use of any medications which have been prescribed, to include proper use of PCA pump, etc.
2. Explain that increasing pain should prompt a visit or call to the patient's provider.
3. Discuss non-pharmacologic measures which may provide pain relief, i.e., sitz bath, massage, change of activity.

PP-WC WOUND CARE

OUTCOME: The patient/family will have an understanding of 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; decreased infection rate, improved healing, etc.
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.

PDEP-DP DISEASE PROCESS

OUTCOME: The patient and family will have an understanding of 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 adherence 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 have an understanding of 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 of strict adherence to 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 breastfeed 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 breast milk, 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-TX TREATMENT

OUTCOME: The patient/family will have an understanding of 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.

PN-1T FIRST TRIMESTER

OUTCOME: The first trimester patient will understand the progression of pregnancy as related to fetal growth and development and changes in her body.

STANDARDS:

1. Explain the reproductive cycle. Identify and explain the functions of: the ovaries, ova, fallopian tubes, uterus cervix, placenta and vagina as it relates to pregnancy.
2. Discuss fetal growth and development during the first trimester. Emphasize the importance of regular prenatal care, rest, prescribed vitamins, iron and good nutrition. Relate adequate folate intake to fetal neural tube health.
3. Discuss the importance of appropriate weight gain. Review the food pyramid, suggest foods that should be increased, i.e., those high in folic acid, iron, vitamin A, calcium; and those to be limited or avoided, i.e., those high in salt, fat, caffeine and empty calories.
4. Emphasize the importance of complete abstinence from drugs, alcohol and tobacco. Point out that use of drugs and/or alcohol during pregnancy can result in birth defects or other complications. Evaluate the patient's use of substances and refer for treatment as appropriate. **Refer to [CD](#).**
5. Teach the patient to inform all health care providers of her pregnancy prior to obtaining treatment (x-rays, medications, etc.).
6. Discuss the importance of good personal and dental hygiene as it relates to good health and positive self-image. Discuss the dangers of fetal overheating in relation to hot baths, jacuzzis, sweat lodges, etc. **Refer to [WL-HY](#).**
7. Discuss relief measures for the discomforts of pregnancy.
8. Discuss sex during pregnancy. Encourage the patient to ask questions.
9. Explain the clinical procedures (exams, lab, sonograms etc.).
10. Emphasize the patient's responsibilities to herself and her growing child. Discuss the dangers of exposure to infectious diseases (measles, toxoplasmosis, STDs, parvovirus, etc.).
11. Emphasize the importance of prepared childbirth classes and parenting classes. Encourage the patient to enroll at the appropriate times.

PN-2T SECOND TRIMESTER

OUTCOME: The second trimester patient will understand the progression of pregnancy as related to fetal growth and development and changes in the body. The patient will begin to discuss the options for feeding the infant.

STANDARDS:

1. Discuss fetal growth and development for the second trimester.
2. Discuss changes in the mother's body during the second trimester. Discuss exercise, rest, and relief measures for second trimester discomforts of pregnancy.
3. Discuss breast-feeding vs. bottle-feeding. Emphasize the advantages of breastfeeding for both mother and baby. **Refer to [BF](#).**
4. Identify risks and warning signs for preterm labor (bleeding, cramping, unexplained abdominal pain, etc.).

PN-3T THIRD TRIMESTER

OUTCOME: The third trimester patient will understand the progression of pregnancy as related to fetal growth and development and changes in the body. The patient will understand the labor and delivery process and how to care for a newborn.

STANDARDS:

1. Discuss changes in the mother's body during the third trimester. Discuss exercise, rest, and relief measures for third trimester discomforts of pregnancy.
2. Discuss the anatomy and physiology of lactation and care of the breasts and nipples. **Refer to [BF](#).**
3. Discuss sex during the late stages of pregnancy and early postpartum period. Discuss methods of contraception. Emphasize the importance of partner participation in family planning.
4. Discuss the signs of impending labor. Discuss those events that require immediate attention e.g., ruptured membranes, bleeding, fever. Emphasize the importance of knowing "when you are in labor" and when to seek medical attention.
5. Discuss the three stages of labor. Discuss the possibility of a C-section.
6. Review breathing exercises for labor. If feasible, refer the patient for childbirth education classes.
7. Discuss hospital admission routines e.g. fetal monitoring, IVs, induction.

PN-BH BEHAVIORAL HEALTH

OUTCOME: The patient/family will understand some of the mental and emotional changes that may take place during and after pregnancy.

STANDARDS:

1. Discuss that pregnancy is a state of hormonal flux and may result in rapid and unpredictable mood swings.
2. Discuss any pre-existing mental or emotional health conditions in the patient or the patient's family.
3. Explain that although some emotional changes may be normal, others may require medication and/or other forms of treatment.
4. Discuss the signs and symptoms of post-partum depression. **Refer to [PDEP](#).**
5. Refer to mental health or other resources as appropriate.

PN-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications of pregnancy and the appropriate action to take.

STANDARDS:

1. Discuss the symptoms of pre-term labor. Emphasize the importance of immediate evaluation by a physician if you think you may have pre-term labor. Explain that immediate treatment may decrease the risk of neonatal death or lost pregnancy. Discuss that even with appropriate treatment pre-term labor may have a catastrophic outcome.
2. Explain that any bleeding as heavy as a period should prompt an immediate evaluation by a physician. Explain that this bleeding may be an early sign of miscarriage. Explain that immediate evaluation by a physician may in some cases reduce the risk of neonatal death or lost pregnancy.
3. Explain that decreased fetal movement should prompt an immediate evaluation in labor and delivery or in another appropriate setting.
4. Emphasize to the patient that pregnancy induced hypertension may be asymptomatic or may be accompanied by warning signs (persistent swelling, persistent headaches, visual changes, decreased fetal movement, sudden weight gain, nausea and vomiting in the third trimester.) Stress that immediate medical attention should be sought if warning signs occur. **Refer to [PN-PIH](#).**

PN-CD CHEMICAL DEPENDENCY

OUTCOME: The patient/family will understand the disease process of chemical dependency/substance abuse and its relationship to fetal development and develop motivation for change.

STANDARDS:

1. Emphasize the importance of complete abstinence from alcohol, inhalants, other drugs and tobacco. Point out that use of alcohol, inhalants and other drugs during pregnancy are associated with birth defects or other complications. Evaluate the patient's use of substances and refer for treatment as appropriate. **Refer to [CD](#).**
2. Administer CAGE or other screening instrument.
3. Discuss that alcohol use during pregnancy is directly associated with an identifiable syndrome in the child. This syndrome can cause developmental delay, hyperactivity, emotional and behavioral problems, mental retardation, learning disabilities, and decreased ability to function independently as an adult. This syndrome has been called fetal alcohol syndrome, fetal alcohol effect and pervasive developmental delay.
4. Review treatment options available.
5. Refer to community resources as available or appropriate.

PN-DC DENTAL CARIES

OUTCOME: The patient/family will understand how maternal oral hygiene and diet affect dental conditions in the mother and infant.

STANDARDS:

1. Explain that tooth decay (dental caries) is partially caused by bacteria in the mouth.
2. Explain that this bacteria can be transmitted from the mother to the infant.
3. Emphasize the importance of the prenatal patient having a dental exam and treating dental caries before the birth of the infant.
4. Discuss proper oral hygiene. **Refer to [DC-P](#).**
5. Discuss the importance of early oral hygiene for the infant—even before eruption of the primary teeth.
6. Discuss the necessity of adequate calcium in the diet of prenatal patients to prevent calcium loss from bones and teeth.

PN-DV DOMESTIC VIOLENCE

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

STANDARDS:

1. Discuss the patient/family members' abusive/violent disorder.
2. Discuss the patient's and other 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.
7. Be sure family members and other victims are aware of shelters and other support options available in their area. Make referrals as appropriate.
8. Assist to develop a plan of action which will insure safety of all people in the environment of violence.

PN-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.

PN-GDM GESTATIONAL DIABETES

OUTCOME: The patient/family will understand diabetes or carbohydrate intolerance during pregnancy and establish a plan for control.

STANDARDS:

1. Emphasize weight control and management of blood sugar.
2. Discuss careful monitoring and tracking of blood sugar.
3. Discuss the increased risk for Type 2 Diabetes in later life in patients who develop gestational diabetes.
4. Discuss the effect of gestational diabetes on the infant (hypoglycemia in the early neonatal period, respiratory distress, complications of delivery, increased incidence of obesity and future development of Type 2 diabetes.).
5. Explain that development of gestational diabetes in this pregnancy places the patient (mother) at high risk for development of gestational diabetes in the future pregnancies and emphasize that prenatal care for future pregnancies should begin prior to conception.

PN-GEN GENETIC TESTING

OUTCOME: The patient/family will understand that some diseases or conditions are inherited and that testing may be recommended in certain circumstances.

STANDARDS:

1. Explain to the patient/family that some diseases or birth defects can be detected during pregnancy.
2. Explain that not all patients are at equal risk for these conditions.
3. Explain that testing may include ultrasound, blood tests, amniocentesis, etc. Discuss the timing of tests as appropriate.
4. Administer the screening questionnaire that is standard for your institution (for example the ACOG antepartum genetic screening questionnaire).
5. Refer appropriate patients to a physician or other provider for further evaluation.

PN-HIV HUMAN IMMUNODEFICIENCY VIRUS

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 adherence 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.

PN-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

PN - M MEDICATIONS

OUTCOMES: 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 strict adherence to the medication regimen and monitoring schedule.
3. Instruct patient on proper administration of the drug.

PN-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition in pregnancy as related to maternal health, fetal growth, and development.

STANDARDS:

1. Describe an adequate pattern of weight gain in pregnancy. Explain the rationale for such gain.
2. Explain the actions to take if the patient develops constipation, nausea, vomiting or pica.
3. Encourage adequate calcium intake. Discuss calcium sources (milk and milk products, calcium supplements, salmon, etc.) **Refer to [OS-N](#)** for other sources of calcium.
4. Discourage weight reduction attempts, skipping meals, and the adverse effect of consuming junk foods during pregnancy.
5. Encourage stress reduction, as stress adversely affects nitrogen and calcium.
6. Explain that breastfeeding in the postpartum period may result in a more rapid return to pre-pregnancy weight.
7. Encourage the patient to limit her intake of aspartame-sweetened foods and caffeinated beverages.
8. Encourage liberal intake of water.
9. Discuss with patient eligibility for supplemental food programs such as WIC, food distribution/commodity programs, food stamps, etc.

PN-PIH PREGNANCY INDUCED HYPERTENSION AND PRE-ECLAMPSIA

OUTCOME: The patient/family will understand the risk, symptoms, and treatment of pregnancy-induced hypertension and pre-eclampsia.

STANDARDS:

1. Explain the difference between systolic and diastolic blood pressure. Define normal ranges.
2. Review predisposing factors for hypertension (obesity, high sodium intake, high fat and cholesterol intake, lack of exercise, etc.).
3. Discuss the special condition of pregnancy as a contributing factor to hypertension - either by worsening existing hypertension or by new onset of pre-eclampsia.
4. Emphasize to the patient that pregnancy-induced hypertension may be asymptomatic or may be accompanied by warning signs (persistent swelling, persistent headaches, visual changes, decreased fetal movement, sudden weight gain, nausea and vomiting in the third trimester.) Stress that medical attention should be sought if warning signs occur.
5. Discuss complications and increased perinatal risk (maternal convulsions with attendant risk of maternal and/or fetal brain injury, premature birth, etc.).

PN-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand some techniques for reducing the pains and discomforts which are sometimes associated with pregnancy.

STANDARDS:

1. Explain that headaches, abdominal pain, back pain, and certain other pains are common and expected in pregnancy.
2. Discuss types of pain which should prompt an immediate medical evaluation, i.e., pains which come and go at regular intervals, pain associated with bleeding, pain which is unrelieved by conservative measures.
3. Discuss measures which may relieve pain, i.e., warm bath, change of activity (walking, etc.), massage.
4. Explain that most pain medications should not be used in pregnancy, but that the patient's provider can recommend and/or prescribe pain medication if necessary.

PN-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand safety measures specific to pregnancy.

STANDARDS:

1. Discuss the regular use of seat belts and children's car seats, obeying the speed limit. Explain that seatbelts clearly save lives and should be worn by all persons including pregnant women.
2. Discuss that seatbelts should be worn low on the hips and the shoulder belt should lie above the pregnant abdomen.
3. Review the dangers inherent in the use of wood-burning stoves, "charcoal pans", kerosene heaters, and other open flames.
4. Review the safe use of electricity and gas.
5. Discuss the proper disposal of waste, including sharps and hazardous materials.
6. Review the proper handling, storage and preparation of food.
7. Review the importance of uncontaminated water sources. Discuss the importance of purifying any suspect water by boiling or chemical purification.
8. Identify which community resources promote safety and injury prevention. Provide information regarding key contacts for emergencies, e.g., 911, Poison Control, hospital ER, police.

PN-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 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 children and adults when exposed to cigarette smoke either directly or via second-hand smoke, i.e., increased colds, asthma, ear infections, pneumonia, lung cancer, etc.
4. Emphasize that the infants who live in the homes where people smoke in the house are three times more likely to die of SIDS than infants who live in a home where no one smokes in the house.
5. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the child is not in the room at the time that the smoking occurs.
6. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure such as smoking outside and wearing a smock which is removed prior to returning to the house.
7. Encourage smoking cessation or at least never smoking in the home or car.

PN-SOC SOCIAL HEALTH

OUTCOME: The patient family will have an understanding of social services available.

STANDARDS:

1. Discuss the patient's living situation including access to adequate housing, electricity, refrigeration, sanitation, running water, and adequate and nutritional foods.
2. Discuss the patient's access to transportation. Refer to community resources as available.
3. Discuss the patient's eligibility for state, federal or tribal resource programs including WIC, state Medicaid, food stamps, commodities, housing assistance, etc. Emphasize that IHS and/or ITU programs may not be able to meet all of the patient's needs therefore she should apply for all programs for which she may be eligible.
4. Refer to community resources as appropriate.

PN-STD SEXUALLY TRANSMITTED DISEASE

OUTCOME: The patient and partner will understand risk factors, transmission, symptoms and complications of causative agent(s).

STANDARDS

1. Discuss specific STDs.
2. Explain how STDs are transmitted, i.e., semen, vaginal fluids, blood, mother to infant during pregnancy or child birth, or breast-feeding.
3. Explain how STDs cannot be transmitted, i.e., casual contact, toilet seats, eating utensils, coughing.
4. Explain that there are no vaccines against STDs and that there is no immunity to STDs. List curable and incurable STDs. Stress the importance of early treatment.
5. Explain that infection is dependent upon behavior, not on race, age, or social status.
6. Describe how the mother/fetus is affected.
7. List symptoms of disease and how long it may take for symptoms to appear.
8. List complications that may result if disease is not treated including complications in the unborn child.
9. Review the actions to take when exposed to an STD.

PN-TO TOBACCO

OUTCOME: The patient/family will understand the dangers of tobacco or nicotine use during pregnancy and make a plan for immediate smoking cessation.

STANDARDS:

1. Review the current factual information regarding tobacco use. Explain that tobacco use in any form is dangerous.
2. Discuss the dangers of tobacco use during pregnancy:
 - a. Low birth weight infants
 - b. Intrauterine growth retardation
 - c. Nicotine withdrawal in the newborn
 - d. Increased incidence of asthma and pneumonia in the child
 - e. Spontaneous abortion or miscarriage
 - f. Placental insufficiency
 - g. Explain nicotine addiction.
3. 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, etc.
4. Review the effects of tobacco use on all family members- financial burden, second-hand smoke, greater risk of fire and premature death of a parent or bread winner.
5. Explain dependency and co-dependency.
6. Discuss that smoking is a serious threat to health. Encourage tobacco cessation.
Refer to [TO](#).

**PL-BIP BILEVEL (OR CONTINUOUS) POSITIVE AIRWAY PRESSURE
VENTILATION**

OUTCOME: The patient/family will verbalize 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 comply with treatment regimens (medications, peak flows, etc.) or from exposure to environmental triggers.
2. Emphasize early medical intervention for minor URI's, fever, cough, and shortness of breath.
3. Stress the importance of adherence to the treatment plan.

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 O₂/CO₂ and resist infection.
3. Explain the patient's specific disease process.

PL-EX EXERCISE

OUTCOME: The patient/family will understand the patient's exercise recommendations or restrictions as appropriate to the disease condition.

STANDARDS:

1. Review the type(s) of exercise recommended for the patient's specific disease.
2. Discuss the importance of consulting the primary provider before beginning any exercise program.

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 treatment plan adherence. 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.

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 verbalize 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 verbalize understanding of 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 which lifestyle changes the patient has the ability to change: cessation of smoking, dietary modifications, weight control, treatment adherence 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 (cigarette smoke, stress, environmental smoke, pollen, mold, dust, roaches, insecticides, paint fumes, perfumes, animal dander, cold air, sulfites, aspirin, etc.) 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 adherence 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 (cigarettes, sparks, flames, etc.).
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 O₂ 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 a more active lifestyle.

PL-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of 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 verbalize 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).

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 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.

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-TO TOBACCO (SMOKING)

OUTCOME: The patient and/or family will have an understanding of 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 verbalize understanding of 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.

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 adherence 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 (lead shields, gloves etc.) 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-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 an 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 have an understanding of 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 under 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 treatment plan adherence. 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 adherence to 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 (masks, blow-by, etc), 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 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.

RSV-TE TESTING

OUTCOME: The patient/family will understand the test(s) to be performed.

STANDARDS:

1. Explain the test(s) ordered (nasopharyngeal wash or swab, pulse oximetry, etc.).
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 have an understanding of 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.

RST-EQ EQUIPMENT

OUTCOME: The patient/family will be instructed on the type of restraint used.

STANDARDS:

1. Explain the hospital policy and procedure to the patient/family.
2. Explain the alternative interventions that may be attempted prior to the use of a physical restraint, i.e., frequent reorientation, position change, modify environment, modifying behavior, scheduled toileting, pain/comfort measures, places closer to nurse's desk, fall risk assessment, encourage family to stay, or there may be no appropriate intervention.
3. Explain the type of restraint to be used on the patient (waist, vest, wrists, ankles, or leather restraints).
4. Explain that nursing assessments will be completed as the hospital policy dictates.
5. Explain to patient/family the necessary conditions for early release from restraints.

RST-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the clinical justification necessitating the restraint of the patient.

STANDARDS:

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

RST-M MEDICATIONS

OUTCOME: The patient/family will understand any medications to be used as a chemical restraint or during the use of mechanical restraints.

STANDARDS:

1. Discuss the use of medications as chemical restraints if appropriate. Discuss common and important side effects.
2. Discuss medications used during the restraint process as appropriate. Discuss common and important side effects.

RST-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand possible safety risks and inform the nursing staff immediately if the patient seems compromised.

STANDARDS:

1. Explain common and important safety risks associated with the type of restraint being used.
2. Emphasize to the patient/family/caregiver the importance of immediately reporting any concern or adverse effect of the restraint. (Cold or blue limbs, restraints around the neck, patient slipping down in the bed, etc.)
3. Explain that the patient will need assistance with hydration and hygiene needs, i.e., toileting.

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 non-adherence with the treatment plan.

RD-DP DISEASE PROCESS

OUTCOME: The patient and 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-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.
2. Review how moderate exercise may increase energy, control weight, improve circulation, enhance sleep, and reduce stress and depression.
3. Review the different types of exercises including active and passive range of motion, and muscle strengthening.
4. If applicable, review and demonstrate the prescribed exercise plan.
5. 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.
6. Caution the patient not to overexert. Exercise should never be done to the point of pain and fatigue.

RD-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of treatment plan adherence 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 medication, rest, exercise, and joint protection.
2. Discuss way to pain management. **Refer to [RD-PM](#).**
3. Review activity limitation and the importance of avoiding fatigue.
4. Discuss ADL aids. Make a referral to social services for assistance in procuring such devices.
5. Explain how exercise and social involvement may decrease the depression and anger often associated with rheumatoid disease.
6. Discuss how self-image, pain, fatigue, inflammation, limited joint mobility, and medications can alter sexual desire and sexual activity.
7. Assess level of acceptance and offer support and referral to social services and community resources as appropriate.
8. Discuss the techniques that may reduce stress and depression such as meditation 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. Discourage the use of alcohol, since it worsens most rheumatic diseases in the long term.

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](#).**

RD-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the patient's pain management program.

STANDARDS:

1. Stress the need to comply 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.

SZ-C COMPLICATIONS

OUTCOME: The patient/family will have an understanding of the potential complications of the patient's seizure disorder.

STANDARDS:

1. Explain some of the complications that may occur during a seizure such as, anoxia from airway occlusion by the tongue or by vomitus, traumatic injury, potential for automobile accident, etc.
2. Explain that uncontrolled seizures may result in progressive brain injury.

SZ-DP DISEASE PROCESS

OUTCOME: The patient/family will have an understanding of 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 treatment plan adherence. 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 adherence 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, etc.
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 adherence 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.

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 adherence 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.

PATIENT EDUCATION PROTOCOLS:SEVERE ACUTE RESPIRATORY SYNDROME

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.

PATIENT EDUCATION PROTOCOLS:SEVERE ACUTE RESPIRATORY SYNDROME

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 adherence 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 adherence to 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 TESTING

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-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and important complications of sexually transmitted diseases.

STANDARDS:

1. Explain that the most common complication of untreated or progressed STD is pelvic inflammatory disease, infertility, and/or sterility.
2. Explain that some STDs if left untreated can progress to disability, disfigurement, and/or death.
3. Discuss that having one sexually transmitted disease greatly increases a person's risk of having a second sexually transmitted disease.
4. Discuss that some sexually transmitted diseases can be life-long or fatal.
5. Discuss the potential for harm to a fetus from the sexually transmitted disease or its treatment.

STD-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.

STD-I INFORMATION

OUTCOME: The patient and partner will understand risk factors, transmission, symptoms and complications of causative agent(s).

STANDARDS

1. Discuss specific STD.
2. Explain how STDs are transmitted, i.e., semen, vaginal fluids, blood, mother to infant during pregnancy or child birth, breast-feeding.
3. Explain how STDs cannot be transmitted, i.e., casual contact, toilet seats, eating utensils, coughing.
4. Explain that there are no vaccines against STDs and that there is no immunity to STDs. List curable and incurable STDs. Stress the importance of early treatment.
5. Explain that infection is dependent upon behavior, not on race, age, or social status.
6. Describe how the body is affected.
7. List symptoms of disease and how long it may take for symptoms to appear.
8. List complications that may result if disease is not treated.
9. Review the actions to take when exposed to an STD.

STD-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

STD-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. Explain that medications may cure bacterial STDs but typically provide only symptomatic relief for viral STDs.
2. Emphasize the importance of adherence 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.

STD-P PREVENTION

OUTCOME: Patient /family will plan behavior patterns which will prevent STD 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.
2. Describe behavior changes which prevent transmission of STDs.
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, etc.
5. Describe how alcohol/substance use and/or abuse can affect ability to use preventive measures.

STD-TE TESTING

OUTCOME: The patient/family will have an understanding of 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 the meaning of test results.

STD-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 disease.
3. Discuss the patient's specific treatment plan.
4. Discuss the importance of routine follow-up and testing as appropriate.

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, etc.
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 fasciotomy 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 that the use of immunosuppressive or corticosteroid medication may increase the risk for skin and wound infections.
6. Explain that elevated blood sugar increases the risk of serious skin and wound infections and impedes healing.
7. Review 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-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.

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 adherence 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 adherence 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-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, etc., 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-WC WOUND CARE

OUTCOME: The patient/family will have an understanding of 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; decreased infection rate, improved healing, etc.
2. Explain the correct procedure for caring for this patient's wound.
3. Explain signs or symptoms that would prompt immediate follow-up; increasing redness, purulent discharge, fever, increased swelling or pain, etc.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained and proper methods for disposal of used supplies.
5. Emphasize the importance of follow-up.

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 adherence to 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 and family, emphasizing the need for follow-up appointment and medication adherence.

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 have an understanding of 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 strict adherence to the medication regimen, 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 have an understanding of 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-I INFORMATION

OUTCOME: Parents/Family will have an understanding of 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-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-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 [CD](#).**
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.

SPE-C COMPLICATIONS

OUTCOME: The patient/family will have an understanding of the common and important complications of the proposed procedure.

STANDARDS:

1. Discuss the common and important complications of the proposed procedure.
2. Discuss alternatives to the proposed procedure.

SPE-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Explain the procedure for obtaining appointments.

SPE-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the surgical procedure or endoscopy.

STANDARDS:

1. Provide the patient/family with written patient information literature on the surgical procedure or endoscopy.
2. Discuss the content of the patient information literature with the patient/family.

SPE-PM PAIN MANAGEMENT

OUTCOME: The patient/family will have an understanding of 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.

SPE-PO POSTOPERATIVE

OUTCOME: Patient and/or family will be knowledgeable about the post-operative course and home management as appropriate.

STANDARDS:

1. Review post-op routine.
2. Discuss symptoms of complications.
3. Review plan for pain management.
4. Discuss home management plan in detail, including signs or symptoms which should prompt re-evaluation.
5. Emphasize the importance of adherence with the plan for follow-up care.

SPE-PR PREOPERATIVE

OUTCOME: Patient/family will be prepared for surgery or other procedure.

STANDARDS:

1. Explain pre-operative preparation, including bathing, bowel preps, diet instructions, etc.
2. Explain the proposed surgery or other procedure including anatomy and physiology, alteration in function, risks, benefits, etc.
3. Discuss common or potentially serious complications.
4. Explain the usual pre-operative routine for the patient's procedure.
5. Discuss what to expect after the procedure.
6. Discuss pain management.

SPE-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, benefits, and common and important complications of the proposed procedure. Discuss the possible results of non-treatment.
2. Explain the process and what to expect after the procedure.
3. Explain the necessary preparation, i.e., bowel preps, diet instructions, bathing.

SPE-WC WOUND CARE

OUTCOME: The patient/family will have an understanding of 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; decreased infection rate, improved healing, etc.
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.

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, etc.
2. Review the effects of tobacco use on all family members- financial burden, second-hand smoke, greater risk of fire, early death of a bread-winner.

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 an exercise program as part of rehabilitation and maintenance of tobacco abstinence.

STANDARDS:

1. Review the benefits of regular exercise, i.e., reduced stress, weight control, increased self-esteem and overall sense of wellness.
2. Refer to [WL-EX](#).

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".

TO-M MEDICATIONS

OUTCOME: If applicable, the patient/family will understand the importance of complying 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 adhere 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 and family.
4. Review the value of close F/U and support during the first months of cessation.

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. Encourage smoking cessation or at least never smoking in the home or car.

TB-DOT DIRECTLY OBSERVED THERAPY

OUTCOME: The patient and family will understand the importance of complying 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 adherence / non-adherence. Discuss the consequences of non-adherence.
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 (respiratory, lymphatic, etc.).
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 adherence.

STANDARDS:

1. Discuss the use, benefits, and common side effects of prescribed medications.
2. Emphasize the importance of adherence and completion of therapy. Explain that drug resistance is increased by incomplete courses of therapy.
3. Discuss the consequences of non-adherence.

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 (hand washing, covering the mouth when coughing or sneezing, disposing of contaminated materials, etc.).
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.

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-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 have an understanding of 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 have an understanding of 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-TE TESTS

OUTCOME: The patient/family will have an understanding of 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 have an understanding of the appropriate treatment for ulcerative colitis and verbalize a plan to adhere to 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-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, etc.
4. Discuss signs and symptoms of an upper respiratory infection, i.e., malaise, rhinorrhea, sneezing, scratchy throat, etc.

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, etc.
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, etc.

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, etc.
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-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 and 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 and family will verbally summarize their medication regimen and the importance of adherence with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications.
Refer to [M](#).
3. Discuss importance of adherence 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 and 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 and family will understand the importance of a nutritionally balanced diet as related to UTI's.

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 have an understanding of precipitating factors for UTIs and will make a plan to minimize recurrence.

STANDARDS:

1. Discuss importance of adherence to 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-TE TESTS

OUTCOME: The patient and 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.

WL-EX EXERCISE

OUTCOME: The patient will relate exercise and/or physical fitness to health promotion and disease prevention.

STANDARDS:

1. Review the benefits of regular exercise.
2. Discuss the three types of exercise: aerobic, flexibility, and endurance.
3. Review the basic recommendations of any exercise program:
4. If any chronic health problems exist, consult with a health care provider.
5. Start out slowly.
6. Exercise a minimum of three times a week.
7. Review the exercise programs available in the community.

WL-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Review the procedure for obtaining follow-up care.
3. Emphasize the importance of keeping appointments.

WL-HY HYGIENE

OUTCOME: The patient will recognize personal routine hygiene as an important part of wellness.

STANDARDS:

1. Review bathing habits, paying special attention to face, pubic hair area and feet. Discuss hygiene as part of a positive self image.
2. Review the importance of daily dental hygiene, with attention to brushing and flossing.
3. Discuss the importance of hand-washing in infection control especially in relationship to food preparation/consumption, child care and toilet use.
4. Discuss the importance of covering the mouth when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

WL-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

WL-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will be able to explain at least one lifestyle change necessary to improve mental or physical health.

STANDARDS:

1. Review the concept that health or wellness refers to the whole person (mind, body and spirit) and is a positive state of health which results from appropriate habits and lifestyle.
2. Review lifestyle aspects/changes that the patient has control over - diet, exercise, safety and injury prevention, and avoidance of high risk behaviors (e.g. smoking, alcohol and substance abuse, sex with multiple partners).
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Practice new knowledge.
 - d. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

WL-N NUTRITION

OUTCOME: The patient will relate diet to health promotion and disease prevention.

STANDARDS:

1. Assess current nutritional habits.
2. Discuss the importance of the food pyramid.
3. Review the relationship of calories to energy balance and body weight.
4. Emphasize the importance of limiting snack foods, fatty foods, red meats, reducing sodium consumption and adding more fresh fruits, fresh vegetables, and fiber to the diet.
5. Emphasize the necessary component —WATER— in a healthy diet. Reduce the use of colas, coffee and alcohol.
6. Review which community resources exist to assist with diet modification and weight control.
7. Stress the importance of being a smart shopper.

WL-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient will be able to identify at least one way to reduce injury risk.

STANDARDS:

1. Discuss the regular use of seat belts and children's car seats, obeying the speed limit, and avoiding the use of alcohol while in a vehicle.
2. Discuss poison prevention, i.e., proper storage and safe use of medicines, cleaners, auto products, paints, etc.
3. Discuss current recommendations for use of ipecac syrup.
4. Review the dangers inherent in the use of wood-burning stoves, "charcoal pans", kerosene heaters, and other open flames.
5. Review the safe use of electricity and gas.
6. Discuss the proper disposal of waste, including sharps and hazardous materials.
7. Review the proper handling, storage and preparation of food.
8. Review the importance of uncontaminated water sources. Discuss the importance of purifying any suspect water by boiling or chemical purification.
9. Identify which community resources promote safety and injury prevention. Provide information regarding key contacts for emergencies, e.g., 911, Poison Control, hospital ER, police.

WL-SCR SCREENING

OUTCOME: The patient/family will understand the proposed screening test including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed screening test. (guaiac, blood pressure, hearing, vision, development, mental health, etc.).
2. Explain the process and what to expect after the test.
3. Emphasize the importance of follow-up care.

WL-SX SEXUALITY

OUTCOME: The patient will have an understanding of how sexuality relates to wellness.

STANDARDS:

1. Review sexuality as an integral part of emotional and physical health.
2. Discuss how sexual feelings play a part in each person's personal identity.
3. Discuss sexual feelings as an important part of interpersonal relationships.
4. Discuss how sexuality varies with gender, age, life-stage, and relationship status.
5. Explain the preventive measures for STDs. **Refer to [STD-P](#).**
6. Review the community resources available for sexual counseling or examination.

WH-BE BREAST EXAM

OUTCOME: The patient will understand the importance of monthly breast self-examination, annual clinical breast exam, and mammograms as appropriate.

STANDARDS:

1. Discuss breast anatomy and the normal changes that occur with pregnancy, menstruation and age.
2. Explain that fibrocystic changes of the breast are a normal finding and become more common with increasing age. Explain that fibrocystic changes may be exacerbated by intake of caffeine.
3. Emphasize the importance of monthly examination in early detection of breast cancer. Survival rates are markedly higher when cancer is detected and treated early.
4. Teach breast self-exam. Have the patient give a return demonstration.
5. Discuss indications for mammography and current recommendations for screening mammograms. Patients who have first degree relatives (mother, sister or daughter) with breast cancer are at higher risk and are encouraged to follow a risk-specific mammogram schedule.
6. Discuss the importance of routine annual clinical examination.

WH-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.

WH-HY HYGIENE

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

STANDARDS:

1. Review aspects of good personal hygiene such as regular bathing, paying special attention to perineal area. Review the importance of wiping front to back to prevent bacterial contamination of the vagina and urethra.
2. Refer to [WL-HY](#).

WH-KE KEGEL EXERCISE

OUTCOME: The patient will understand how to use Kegel exercises to prevent urinary stress incontinence and improve pelvic muscle tone.

STANDARDS:

1. Review the basic pelvic floor anatomy.
2. Define stress incontinence and discuss its causes.
3. Teach Kegel exercises. Encourage frequent practice of Kegel exercises.

WH-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about women's health.

STANDARDS:

1. Provide the patient/family written information about women's health.
2. Discuss the content of the written information with the patient/family.

WH-MP MENOPAUSE

OUTCOME: The patient/family will understand the etiology, symptomatology, and relief measures of menopause.

STANDARDS:

1. Explain that around age 45-55 the normal decline in the levels of estrogen and progesterone signals the start of menopause, the permanent cessation of ovulation and menstruation which results in eventual infertility.
2. Review how fluctuating hormone levels may result in the following physical and emotional symptoms: "hot flashes" (dilation of the blood vessels), headaches, dizziness, tachycardia, breast tenderness, fluid retention, decreased vaginal lubrication, unpredictable mood changes, sleep disturbances, fears about changing sexuality, anxiety and depression. These symptoms are troublesome in approximately 20 percent of menopausal women.
3. Review relief measures which include hormone replacement therapy, vaginal lubricants, reducing salt and caffeine, staying active, and seeking psychological support as necessary.
4. Explain that pregnancy is still a risk and that contraception should be used until there has been no menses for 12 consecutive months.

WH-MS MENSES

OUTCOME: The patient will understand the menstrual cycle.

STANDARDS:

1. Discuss comfort measures for dysmenorrhea.
2. Discuss the importance of good menstrual hygiene. Discuss the use and frequent changing of tampons and napkins. Discourage use of super absorbent tampons.
3. Explain that exercise and sex need not be curtailed during menses but that additional hygiene measures should be taken.
4. Explain that it is normal for menstrual cycles to be irregular for several years after menarche.

WH-N NUTRITION

OUTCOME: The patient will relate diet to health promotion and disease prevention.

STANDARDS:

1. Assess current nutritional habits.
2. Discuss the importance of the food pyramid.
3. Review the relationship of calories to energy balance and body weight.
4. Emphasize the importance of limiting snack foods, fatty foods, red meats, reducing sodium consumption and adding more fresh fruits, fresh vegetables, and fiber to the diet. Emphasize that there is a special need for adequate calcium in the diet. **Refer to [OS](#).**
5. Emphasize the necessary component —WATER— in a healthy diet. Reduce the use of colas, coffee and alcohol.
6. Review which community resources exist to assist with diet modification and weight control.
7. Stress the importance of being a smart shopper.

WH-OS OSTEOPOROSIS

OUTCOME: The patient will understand the etiology, symptomatology, prevention and treatment of osteoporosis.

STANDARDS:

1. Discuss the causes of osteoporosis including loss of bone density secondary to reduced estrogen levels and low intake of calcium.
2. Emphasize the importance of prevention. Explain that peak bone density occurs about age 30 and that without intervention, progressive bone loss is typical.
3. Review the risk factors: Low dietary intake of calcium, sedentary lifestyle, familial history, smoking, stress, age over 40, gender, race, stature, and calcium binding medications such as laxatives, antacids, and steroids.
4. Emphasize that treatment is limited to preventing osteoporosis and/or slowing the progression of the disease. It is very important to prevent osteoporosis by a calcium-rich diet, regular weight-bearing exercise, decreased stress, not smoking, reduced alcohol intake, and estrogen replacement as appropriate.
5. Discuss the sequelae including stooped shoulders, loss of height, back, neck and hip pain, and susceptibility to fractures.

WH-PAP PAP SMEAR

OUTCOME: The patient will understand the importance of routine Pap testing after onset of sexual activity or 18 years of age, whichever comes first.

STANDARDS:

1. Explain that the purpose of the Pap test is to screen for precancerous conditions.
2. Emphasize that precancerous conditions of the cervix are highly treatable.
3. Emphasize the importance of routine Pap tests. Encourage the patient to associate the Pap routine with an important date such as her birthday.
4. If this is other than an annual Pap test, explain the reason(s) for the test and the follow-up recommended. Discuss the results of the original test as appropriate.

WH-PMS PREMENSTRUAL SYNDROME

OUTCOME: The patient/family will understand the symptoms and relief measures for Premenstrual Syndrome (PMS).

STANDARDS:

1. Discuss Premenstrual Syndrome. Explain that it is a combination of physical and emotional symptoms resulting from fluctuations in the levels of estrogen and progesterone that occur 5-10 days before the onset of the menstrual period.
2. Review relief measures which include: physical activity, limiting intake of fat and salt, increasing water intake to 8 glasses daily, no limitation of sexual activity, supplemental vitamin B6 or calcium. Diuretics may help relieve some of the symptoms of PMS.

WH-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed procedure.
2. Explain the process and what to expect after the procedure.
3. Emphasize the importance of follow-up care.

WH-RS REPRODUCTIVE SYSTEM

OUTCOME: The patient/family will understand the normal anatomy and physiology of the female reproductive system.

STANDARDS:

1. Review the reproductive anatomy and discuss the reproductive cycle.
2. Discuss the importance of good hygiene.
3. Explain that sexually transmitted diseases can impair fertility. **Refer to [STD](#).**
4. Because the risk of cervical cancer is increased by early sexual activity and multiple partners, encourage abstinence or monogamy as appropriate.

WH-STD SEXUALLY TRANSMITTED DISEASES (REFER TO CODES FOR STD)**WH-TE TESTS**

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, expected benefits, and the risks of non-testing.

STANDARDS:

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

PATIENT EDUCATION PROTOCOLS:DIABETES CURRICULUM EDUCATION CODES

What are the Diabetes Curriculum Education Codes?

The Diabetes Education Curriculum Codes are a VERY specific set of codes that follow the IHS Diabetes Curriculum. They are meant to be used by persons who are familiar with the IHS Diabetes Curriculum. Mostly this will be diabetes educators, however, if you are another type of provider who is familiar enough with the IHS Diabetes Curriculum to use these specific codes correctly, check with your local Diabetes Program about their use.

Most providers who document diabetes education will want to use the [DM](#) codes found in the main set of patient education codes.

DMC-ABC KNOWING YOUR NUMBERS (ABC)

OUTCOME: The individual/family will be able to identify target goals for A1c, blood pressure and blood fat levels.

STANDARDS:

- ABC-1 Verbalize one reason for measuring A1c.
- ABC-2 State the target A1c goal for blood sugar control.
- ABC-3 Identify current A1c.
- ABC-4 State two ways to reach or maintain their A1c goal.
- ABC-5 Verbalize one reason for measuring blood pressure.
- ABC-6 State the target for blood pressure control.
- ABC-7 Identify current blood pressure.
- ABC-8 State two ways to reach or maintain a target blood pressure.
- ABC-9 Verbalize one reason for measuring blood fats.
- ABC-10 State the target goals for target blood fats
- ABC-11 Identify at least one current blood fat level.
- ABC-12 List two or more ways to reach or maintain target blood fat goals.
- ABC-13 State where to get help to improve their ABC numbers.
- ABC-GS State or write a plan to reach or maintain at least one of the ABC numbers.
- ABC-GM Behavior goal met (follow-up)
- ABC-GNM Behavior goal unmet (follow-up)

DMC-AC ACUTE COMPLICATIONS

OUTCOME: The individual/family will understand acute complications and self-care actions to take to prevent or treat acute complications.

STANDARDS:**LOW BLOOD SUGAR**

- AC-1 Define low blood sugar.
- AC-2 Discuss two or more causes of low blood sugar.
- AC-3 List two or more symptoms of low blood sugar.
- AC-4 State two or more actions to take when feeling symptoms of low blood sugar.
- AC-5 State two or more actions to prevent low blood sugar.

HIGH BLOOD SUGAR

- AC-6 Define high blood sugar.
- AC-7 State two or more causes of high blood sugar.
- AC-8 List two or more symptoms of high blood sugar.
- AC-9 Discuss two or more actions to take when the blood sugar is high.
- AC-10 State two or more actions to prevent high blood sugar.

SICK DAY MANAGEMENT

- AC-11 Explain how blood sugar is affected during illness.
- AC-12 State two or more things to do to manage blood sugar when sick.
- AC-13. Identify two or more food and drink choices to use when sick.
- AC-GS State or write a plan to use for low blood sugar, high blood sugar, and sick day management.
- AC-GM Behavior goal met (follow-up)
- AC- GNM Behavior goal unmet (follow-up)

DMC-BG BEHAVIORAL GOALS (MAKING HEALTHY CHANGES)

OUTCOME: The individual/family will have a basic knowledge of the process of behavior change and goal setting.

STANDARDS:

- BG-1 State in simple terms what a goal is.
- BG-2 Discuss personal habits.
- BG-3 Identify desirable behavioral changes.
- BG-4 Describe the process for making personal change.
- BG-GS State or write a plan to change one or more behaviors.
- BG-GM Behavior goal met (follow-up)
- BG-GNM Behavior goal unmet (follow-up)

DMC-BGM BLOOD SUGAR MONITORING, HOME

OUTCOME: The individual/family will understand the importance of blood sugar monitoring, know how to use the meter, and make personal blood sugar monitoring plan.

STANDARDS:

- BGM-1 Explain that people with diabetes use a meter to learn how much sugar is in the blood.
- BGM-2. List benefits of checking blood sugar.
- BGM-3 State target blood sugar ranges to decrease risk for complications.
- BGM-4 Discuss personal blood sugar goals.
- BGM-5 State when to check blood sugar.
- BGM-6 Discuss proper technique for checking blood sugar. (To include maintenance, support services)
- BGM-7 Demonstrate how to record results correctly.
- BGM-8 Discuss benefits of bringing meter and logbooks to clinic visits.
- BGM-9 State proper disposal of sharps.
- BGM-10 State how to get supplies to check blood sugar.
- BGM-GS State or writes a plan to check blood sugar.
- BGM-GM Behavior goal met (follow-up)
- BGM-GNM Behavior goal unmet (follow-up)

DMC-CC CHRONIC COMPLICATIONS (PREVENTING AND TREATING DIABETES COMPLICATION)**STAYING HEALTHY WITH DIABETES**

OUTCOME: The individual/family will understand the prevention and treatment of long-term complications of diabetes.

STANDARDS:

- CC-1 State that controlling blood sugar lowers the chance of getting diabetes complications.
- CC-2 Identify two or more factors that increase the risk of complications.
- CC-3 State two or more long-term complications of diabetes

RETINOPATHY

- CC-4 Describe retinopathy in their own words.
- CC-5 List at least two or more ways to prevent or delay eye disease.
- CC-6 Discuss how eye disease is treated.

HEART DISEASE

- CC-7 Define heart disease in their own words.
- CC-8 List at two or more ways to prevent or delay heart disease.
- CC-9 Discuss how heart disease is treated.

NEPHROPATHY

- CC-10 Define nephropathy in their own words.
- CC-11 List at two or more ways to prevent or delay kidney disease.
- CC-12 Discuss how kidney disease is treated.

NEUROPATHY

- CC-13 Define neuropathy in their own words.
- CC-14 List two or more to prevent or delay nerve damage.
- CC-15 Discuss how nerve damage is treated.(To include pain management)

SEXUAL HEALTH AND DIABETES

- CC-16 Discuss in simple terms how diabetes and high blood sugars may impact intimacy/sexuality.
- CC-17 List two or more ways to prevent or delay sexual health problems.
- CC-18 Discuss how sexual health problems are treated.
- CC-19 Discuss ways to talk about sexual concerns with significant others and members of the health care team.

PERIODONTAL

- CC-20 Describe periodontal disease in their own words.
- CC-21 List at two or more ways to prevent or delay gum/teeth problems.
- CC-22 Discuss how periodontal disease is treated.

SUMMARY

- CC-23 Describe the need for all people with diabetes to get yearly tests, exams, and immunizations.
- CC-24 Identify their risk factors for diabetes complications.
- CC-GS State or write at least one behavior change that will help lower their risk for diabetes complications.
- CC-GM Behavior goal met (follow-up)
- CC-GNM Behavior goal unmet (follow-up)

DMC-DP DISEASE PROCESS (WHAT IS DIABETES)**BALANCING YOUR LIFE AND DIABETES**

OUTCOME: The individual/family will have a basic understanding of the definition, pathophysiology, and treatment of Type 2 diabetes.

STANDARDS:

- DP-1 Provide a simple definition for diabetes in their own words
- DP-2 Discuss the differences between Type 1 and Type 2 diabetes.
- DP-3 Explain how the body normally uses food.
- DP-4 List two or more risk factors for developing diabetes.
- DP-5 Describe the impact of insulin resistance in diabetes.
- DP-6 List two or more signs or symptoms of high blood sugar.
- DP-7 State the range for normal fasting blood sugar.
- DP-8 State a normal blood sugar range one to two hours after a meal.
- DP-9 Explain that high blood sugar can cause damage to the nerves and blood vessels in the eyes, heart, kidneys, and feet.
- DP-10 List two or more diabetes self-care actions necessary to reach target blood sugar goals.
- DP-GS State or write one change to make for diabetes self-care.
- DP-GM Behavior goal met (follow-up)
- DP-GNM Behavior goal unmet (follow-up)

DMC- EX EXERCISE (MOVING TO STAY HEALTHY)

OUTCOME: The individual/family will understand the relationship of physical activity in achieving and maintaining blood sugar control by making a personal physical activity plan.

STANDARDS

- EX-1 List two or more benefits of regular physical activity.
- EX-2 State effects of physical activity on blood sugar.
- EX-3 Discuss kinds of physical activity.
- EX-4 Discuss time and frequency for physical activity.
- EX-5 Discuss simple ways to measure intensity of physical activity.
- EX-6 Discuss medical clearance issues for physical activity.
- EX-7 List one or more ways to stay safe during physical activity.
- EX-GS State or write a personal plan for physical activity.
- EX-GM Behavior goal met (follow-up)
- EX-GNM Behavior goal unmet (follow-up)

DMC-FTC FOOT CARE (TAKING CARE OF YOUR FEET)

OUTCOME: The individual/family will understand the importance of foot care for people with diabetes.

STANDARDS:

- FTC-1 State one or more reasons to check feet every day.
- FTC-2 Identify two or more risk factors for foot problems.
- FTC-3 List two or more daily self-care action to prevent foot problems.
- FTC-4 Describe how to cut toenails correctly.
- FTC-5 Describe two or more things to look for when choosing proper footwear.
- FTC-6 State two or more signs and symptoms of foot and skin infections.
- FTC-7 State the reason for routine foot exams at each clinic visit and yearly foot screening.
- FTC-GS Demonstrate a personal foot exam and state a personal foot care plan.
- FTC-GM Behavior goal met (follow-up)
- FTC-GNM Behavior goal unmet (follow-up)

DMC-M DIABETES MEDICINE- OVERVIEW AND DIABETES PILLS**DMC-IN DIABETES MEDICINE - INSULIN**

OUTCOME: The individual/family will understand their medicine regiment.

SECTION 1: OVERVIEW

- M-1 Discuss the role of diabetes medicines in the overall diabetes treatment plan
- M-2 State two or more reasons for adding or changing diabetes medicines
- M-3 State the importance of checking blood sugar more often when medicines are changed
- M-4 State the importance of taking medicines as prescribed.
- M-5 State two or more guidelines for when to contact a health care provider for medicine.
- M-6 Discuss the role of alternative treatments for diabetes and how they affect blood sugar (including herbal, traditional healing methods, and over-the-counter medicines).

SECTION 2: DIABETES PILLS

- M7 State the name of their diabetes pills, how much to take, when to take them, how they work, and possible side effects.
- M-GS State or write a personal plan for taking their diabetes pills.
- M-GM Behavior goal met (follow-up)
- M-GNM Behavior goal unmet (follow-up)

SECTION 3: INSULIN

- IN-1 Discuss how insulin works to control blood sugar in persons with Type 2 diabetes.
- IN-2 Describe the type of insulin they use, the name of the insulin, how it works, how much to take, and when to take it.
- IN-3 Identify insulin injection sites.
- IN-4 Demonstrate proper technique for withdrawing and injecting insulin.
- IN-5 Discuss proper storage of insulin.
- IN-6 Discuss proper disposal of insulin syringes and other sharps.
- IN-7 Discuss the major side effect of taking insulin.
- IN-GS State or write a personal plan for taking insulin.
- IN-GM Behavior goal met (follow-up)
- IN-GNM Behavior goal unmet (follow-up)

DMC-MSE MIND, SPIRIT AND EMOTION

OUTCOME: The individual/family will understand the emotional impact of diabetes on their personal lives.

STANDARDS:

MSE-1 Express feelings about having diabetes.

MSE-2 Discuss one or more ways diabetes has affected his/her life and/or the lives of their family members and significant others.

MSE-3 Identify their support person(s).

MSE-4 Share past experiences in dealing with health or other kinds of problems.

MSE-5 Explain the body's response to stress.

MSE-6 Discuss ways to handle stress.

MSE-GS State or write one way to handle a stressful situation.

MSE-GM Behavior goal met (follow-up)

MSE-GNM Behavior goal unmet (follow-up)

DMC-N NUTRITION (BASICS OF HEALTHY EATING)

OUTCOME: The individual/family will understand the basics of healthy eating.

STANDARDS:**SECTION 1: INTRODUCTION TO HEALTHY EATING**

N-1 Describe the effect of food on diabetes.

N-2 State that healthy food choices are good for the person with diabetes and their whole family.

N-3 Describe how timing and consistency of food can help people with diabetes reach their target blood sugar goals.

N-4 Describe the effect of portion sizes on blood sugar.

N-5 State that eating less sugar and fat can help lower blood sugar.

N-6 State how keeping a record of food eaten can help people with diabetes reach their target blood sugar goals.

SECTION 2: BASICS OF HEALTH EATING

N-7 State two or more benefits of healthy food choices for the person with diabetes.

N-8 Record a day's meal onto a food record.

N-9 Discuss the basic food groups.

N-10 Identify the food groups high in carbohydrates and recognize their efforts on blood sugar.

N-11 State that weight loss can help people with diabetes reach their target blood sugar goals.

N-12 Discuss how to find reliable resources for nutrition facts and answers to questions.

N-GS State or write a personal plan for making healthy food choices.

N-GM Behavior goal met (follow-up)

N-GNM Behavior goal not met (follow-up)

SECTION 3: HEART HEALTHY EATING

- N-13 State that heart healthy food choices are good for the person with diabetes and their whole family.
- N-14 Identify foods that increase the risk for heart disease.
- N-15 Identify foods that can decrease risk for heart disease.
- N-16 Identify two or more ways to choose foods to lower the risk of heart disease.

DMC-PPC PRE-PREGNANCY COUNSELING

OUTCOME: The woman with diabetes and her significant other/family will understand the need for blood sugar control prior to pregnancy.

STANDARDS:

- PPC-1 Describe the need to reach target blood sugar goals before becoming pregnant.
- PPC-2 Identify two or more ways to reach target blood sugar goal before becoming pregnant.
- PPC-3 State that insulin injections may be needed to reach target blood sugar goal before becoming pregnant.
- PPC-4 State two potential problems for baby if pregnancy occurs while the mother's blood sugar is high.
- PPC-5 State two potential problems for mother during pregnancy.
- PPC-6 State the need to use birth control until ready to become pregnant.
- PPC-7 State the need to seek early prenatal care.
- PPC-8 State the need to avoid tobacco, alcohol, and drugs before and during pregnancy.
- PPC-9 Identify community resources to support families before, during, and after pregnancy.
- PPC-GS State or write a personal plan to prepare for pregnancy.
- PPC-GM Behavior goal met (follow-up)
- PPC-GNM Behavior goal unmet (follow-up)

GDM-BG BEHAVIORAL GOALS (MAKING HEALTHY CHANGES)

OUTCOME: The individual/family will have a basic knowledge of the process of behavior change and goal setting.

STANDARDS:

- BG1. State in simple terms what a goal is.
- BG2. Discuss personal habits.
- BG3. Identify what the patient may want to change.
- BG4. Describe the process for making personal change.
- BG50. Write one behavior change plan.
- BG51. Behavior goal met (follow-up)
- BG52. Behavior goal unmet (follow-up)

GDM-BGM BLOOD SUGAR MONITORING, HOME

OUTCOME: The individual/family will understand the importance of blood sugar monitoring, know how to use the monitor and make personal blood sugar monitoring plan.

STANDARDS:

- BGM1. Explain that blood is tested to learn how much sugar is in the blood.
- BGM2. List benefits of testing blood sugar.
- BGM3. State blood sugar ranges to decrease risk for complications.
- BGM4. State personal blood sugar goals.
- BGM5. State when to test blood sugar.
- BGM6. Demonstrate proper testing of blood sugar. (To include maintenance, support services)
- BGM7. Demonstrate how to record results correctly.
- BGM8. Discuss benefits of bringing meter and logbooks to clinic visits.
- BGM9. State proper disposal of insulin syringes and other sharps.
- BGM10. States how to get blood sugar testing supplies.
- BGM50. Writes a plan to test blood sugar.
- BGM51. Behavior goal met (follow-up)
- BGM52. Behavior goal unmet (follow-up)

GDM-C COMPLICATIONS

OUTCOME: The woman with gestational diabetes and her significant other/family will understand the relationship between high blood sugars and adverse outcomes of pregnancy.

STANDARDS:

- C1 Discuss 2 complications for mom if blood sugars are high during pregnancy.
- C2 Discuss 2 complications for baby if blood sugars are high during pregnancy.
- C3 Describe the how to monitor fetal movement (kick counts).
- C4 Discuss how to control blood sugar during pregnancy.
- C5 Discuss 2 things she can do to help prevent or control diabetes after delivery.
- C50 Write a personal plan to control blood sugar during pregnancy.
- C51 Behavior goal met (follow-up)
- C52 Behavior goal unmet (follow-up)

GDM-DP DISEASE PROCESS

OUTCOME: The woman with gestational diabetes and her significant other/family will understand diabetes self care management during pregnancy.

STANDARDS:

- DP1 Define in simple terms gestational diabetes.
- DP2 State blood sugar goals for pregnancy.
- DP3 Describe feelings about diabetes and pregnancy.
- DP4 Describe self-care management during pregnancy.
- DP50 Write a personal plan for self care management during pregnancy.
- DP51 Behavior goal met (follow-up)
- DP52 Behavior goal unmet (follow-up)

GDM-EX EXERCISE (PHYSICAL ACTIVITY AND PREGNANCY)

OUTCOME: The woman with gestational diabetes and her significant other/family will have a safe physical activity plan to follow during pregnancy.

STANDARDS:

- EX1 Describe a safe physical activity plan for pregnancy.
- EX2 List 3 guidelines to follow for a safe exercise program.
- EX50 Write a physical activity plan to use during pregnancy.
- EX51 Behavior goal met (follow-up)
- EX52 Behavior goal unmet (follow-up)

GDM-FU FOLLOW-UP

OUTCOME: The individual/family will understand the importance of routine follow-up in diabetes treatment and management.

STANDARDS:

- FU1 Discuss the importance of regular medical appointments and education to prevent or delay the complications of diabetes.
- FU2 States at least 3 standards of diabetes care.
- FU3 States the local process to use to make appointments for clinical, education and other services for people with diabetes.
- FU50 Writes or states a personal plan for follow-up visits.
- FU51 Behavior goal met (follow-up)
- FU52 Behavior goal unmet (follow-up)

GDM-L PATIENT INFORMATION LITERATURE

OUTCOME: The individual/family receives information about diabetes self-care management.

STANDARDS:

- L1 Provided with diabetes self-care management information.
- L2 Provided information about local resources to promote health.

GDM-N NUTRITION (MEAL PLANNING IN PREGNANCY)

OUTCOME: The woman with gestational diabetes and her significant other/family will be able to make a personal plan for nutritional needs during pregnancy.

STANDARDS:

- N1 Discuss in simple terms carbohydrate foods.
- N2 Discuss 2 or more healthy eating changes to control blood sugar during pregnancy
- N3 Discuss importance of consistent timing of meals and snacks.
- N50 Write a personal plan for making nutrition changes during pregnancy.
- N51 Behavior goal met (follow-up)
- N52 Behavior goal unmet (follow-up)

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 17 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. If a provider requires more specific education coding the previously developed codes are still available for use and are preferred where applicable.

This newer, more general system is used in essentially the same way as the existing codes, except that instead of having a patient education diagnosis code the provider will simply write out the diagnosis or condition, followed by the education modifier, followed by level of understanding, and finally the provider initials. For example:

Head lice - TX - P - <provider initials>

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

Head lice - treatment - poor understanding.

If education on more than one topic on the same diagnosis is provided these topics can be separated by commas IF the level of understanding is the same for each topic. For example:

Head lice-P,TX,M,FU-G-<provider initials>.

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

Head lice - prevention, treatment, medication, follow-up - good understanding.

If education is provided on multiple diagnoses and/or the level of understanding varies these must be documented separately. For example:

Head lice - P - P - <provider initials>

Head lice - TX - G - <provider initials>

Impetigo - M, FU - G - <provider initials>

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

Head lice - prevention - poor understanding

Head lice - treatment - good understanding

Impetigo - medications, follow-up - good understanding

Please note that the diagnosis MUST have an associated ICD-9 diagnosis code. These codes must still be documented in the patient education section of the PCC. 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.

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 applicable).
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 adherence with the treatment regimen.
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 verbalize understanding 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 O₂, 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 have an understanding of 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 exercise 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 adherence 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 adherence 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 verbalize understanding of 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 adherence 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, etc.
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 - TESTING

OUTCOME: The patient/family will have an understanding of 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 have an understanding of 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.

**INDIAN HEALTH SERVICE
EDUCATION NEEDS ASSESSMENT CODES****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 (mood disorder, psychotic symptoms, acute stress, anxiety, depression, etc.).
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, etc.).
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-DOIT DO/PRACTICE

OUTCOME: The patient/family will verbalize 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 verbalize 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 verbalize 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 verbalize 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-VIDEO VIDEO

OUTCOME: The patient/family will verbalize 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-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 verbalizes 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 verbalizes 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 verbalizes 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 verbalizes 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.

INDEX OF PATIENT EDUCATION PROTOCOLS

ABD ABDOMINAL PAIN

ABD-C	Complications
ABD-DP	Disease Process
ABD-FU	Follow-up
ABD-L	Patient Information Literature
ABD-M	Medications
ABD-N	Nutrition
ABD-PM	Pain Management
ABD-TE	Tests
ABD-TX	Treatment

AF ADMINISTRATIVE FUNCTIONS

AF-B	Benefits Of Updating Charts
AF-FU	Follow-up
AF-REF	Referral Process

ADM ADMISSION TO HOSPITAL

ADM-EQ	Equipment
ADM-OR	Orientation
ADM-POC	Plan Of Care
ADM-RI	Patient Rights And Responsibilities
ADM-S	Safety And Accident Prevention

ADV ADVANCE DIRECTIVES

ADV-I	Information
ADV-L	Patient Information Literature
ADV-LW	Living Will
ADV-POA	Durable Power Of Attorney For Health Care
ADV-RI	Patient Rights And Responsibilities

AL ALLERGIES

AL-DP	Disease Process
AL-FU	Follow-up
AL-L	Patient Information Literature
AL-LA	Lifestyle Adaptations
AL-M	Medication
AL-N	Nutrition
AL-TE	Tests

AN ANEMIA

AN-C	Complications
AN-DP	Disease Process
AN-FU	Follow-up
AN-L	Patient Information Literature
AN-M	Medications
AN-N	Nutrition
AN-PRO	Procedures
AN-TE	Tests
AN-TX	Treatments

ANS ANESTHESIA

ANS - C	Complications
ANS-EQ	Equipment
ANS - FU	Follow-up
ANS-INT	Intubation
ANS - L	Literature
ANS-PM	Pain Management
ANS - PO	Postoperative
ANS-PR	Preoperative

ABX ANTIBIOTIC RESISTANCE

ABX-C	Complications
ABX-DP	Disease Process
ABX-FU	Follow-up
ABX-L	Literature
ABX-M	Medication
ABX-P	Prevention
ABX-TE	Testing

ACC ANTICOAGULATION

ACC-C	Complications
ACC-DP	Disease Process
ACC-FU	Follow-up
ACC-HM	Home Management
ACC-L	Literature
ACC-LA	Lifestyle Adaptations
ACC-M	Medications
ACC-N	Nutrition
ACC-S	Safety and Injury Prevention
ACC-TE	Tests

INDEX OF PATIENT EDUCATION PROTOCOLS

ASM ASTHMA

ASM-C	Complications
ASM-DP	Disease Process
ASM-EQ	Equipment
ASM-EX	Exercise
ASM-FU	Follow-up
ASM-HM	Home Management
ASM-L	Patient Information Literature
ASM-LA	Lifestyle Adaptations
ASM-M	Medications
ASM-MDI	Metered-Dose Inhalers
ASM-N	Nutrition
ASM-NEB	Nebulizer
ASM-PF	Peak-Flow Meter
ASM-SHS	Second-Hand Smoke
ASM-SPA	Spacers
ASM-TO	Tobacco (Smoking)

ADD ATTENTION DEFICIT HYPERACTIVITY DISORDER

ADD-DP	Disease Process
ADD-FU	Follow-up
ADD-GD	Growth and Development
ADD-L	Patient Information Literature
ADD-LA	Lifestyle Adaptations
ADD-M	Medication
ADD-N	Nutrition
ADD-TE	Tests
ADD-TX	Treatment

ATO AUTOIMMUNE DISORDERS

ATO-C	Complications
ATO-DP	Disease Process
ATO-FU	Follow-up
ATO-L	Patient Information Literature
ATO-LA	Lifestyle Adaptations
ATO-M	Medications
ATO-N	Nutrition
ATO-TE	Testing
ATO-TX	Treatment

BH BEHAVIORAL AND SOCIAL HEALTH

BH-DP	Disease Process
BH-EX	Exercise
BH-FU	Follow-up
BH-L	Patient Information Literature
BH-M	Medications
BH-PSY	Psychotherapy
BH-WL	Wellness

BWP BIOLOGICAL WEAPONS

BWP-C	Complications
BWP-DP	Disease Process
BWP-FU	Follow-up
BWP-I	Information
BWP-L	Literature
BWP-LA	Lifestyle Adaptations
BWP-M	Medications
BWP-P	Prevention
BWP-TE	Testing
BWP-TX	Treatment

BL BLOOD TRANSFUSION

BL-C	Complications
BL-FU	Follow-up
BL-L	Patient Information Literature
BL-S	Safety
BL-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

BF BREAST FEEDING

BF-AP	Anatomy and Physiology
BF-BB	Benefits Of Breastfeeding
BF-BC	Breast Care
BF-BP	Breastfeeding Positions
BF-CS	Collection And Storage Of Breast-Milk
BF-EQ	Equipment
BF-FU	Follow-up
BF-GD	Growth and Development
BF-HC	Hunger Cues
BF-L	Patient Information Literature
BF-LA	Lifestyle Adaptations
BF-M	Maternal Medications
BF-MK	Milk Intake
BF-N	Nutrition (Maternal)
BF-ON	Latch-On
BF-T	Teething
BF-W	Weaning

CA CANCER

CA-AP	Anatomy and Physiology
CA-C	Complications
CA-DP	Disease Process
CA-EQ	Equipment
CA-FU	Follow-up
CA-HM	Home Management
CA-L	Literature
CA-LA	Lifestyle Adaptations
CA-M	Medications
CA-N	Nutrition
CA-P	Prevention
CA-PM	Pain Management
CA-REF	Referral
CA-TE	Tests
CA-TX	Treatment

CVA CEREBROVASCULAR DISEASE

CVA-C	Complications
CVA-DP	Disease Process
CVA-EQ	Equipment
CVA-FU	Follow-up
CVA-HM	Home Management
CVA-L	Patient Information Literature
CVA-LA	Lifestyle Adaptations
CVA-M	Medications
CVA-N	Nutrition
CVA-P	Prevention
CVA-S	Safety and Injury Prevention
CVA-TE	Tests
CVA-TX	Treatments

CD CHEMICAL DEPENDENCY

CD-C	Complications
CD-DP	Disease Process
CD-EX	Exercise
CD-FU	Follow-up
CD-HM	Home Management
CD-L	Patient Information Literature
CD-LA	Lifestyle Adaptations
CD-M	Medications
CD-N	Nutrition
CD-P	Prevention

CP CHEST PAIN

CP-DP	Disease Process
CP-FU	Follow-up
CP-L	Patient Information Literature
CP-M	Medications
CP-N	Nutrition
CP-TE	Testing

CHN CHILD HEALTH NEWBORN (0-60 DAYS)

CHN-FU	Follow-up
CHN-GD	Growth and Development
CHN-I	Information
CHN-L	Patient Information Literature
CHN-N	Nutrition
CHN-PA	Parenting
CHN-S	Safety and Injury Prevention
CHN-SHS	Second-Hand Smoke

INDEX OF PATIENT EDUCATION PROTOCOLS

CHI CHILD HEALTH INFANT (2-12 MONTHS)

CHI-FU	Follow up
CHI-GD	Growth and Development
CHI-L	Patient Information Literature
CHI-N	Nutrition
CHI-PA	Parenting
CHI-S	Safety and Injury Prevention
CHI-SHS	Second-Hand Smoke
CHI-W	Weaning

CHT CHILD HEALTH TODDLER (1-3 YEARS)

CHT-FU	Follow-up
CHT-GD	Growth and Development
CHT-L	Patient Information Literature
CHT-N	Nutrition
CHT-PA	Parenting
CHT-S	Safety and Injury Prevention
CHT-SHS	Second-Hand Smoke
CHT-W	Weaning

CHP CHILD HEALTH PRESCHOOL (3-5 YEARS)

CHP-FU	Follow up
CHP-GD	Growth and Development
CHP-L	Patient Information Literature
CHP-N	Nutrition
CHP-PA	Parenting
CHP-S	Safety and Injury Prevention
CHP-SHS	Second-Hand Smoke

CHS CHILD HEALTH SCHOOL AGE (5-12 YEARS)

CHS-FU	Follow-up
CHS-GD	Growth and Development
CHP-L	Patient Information Literature
CHS-N	Nutrition
CHS-PA	Parenting
CHS-S	Safety and Injury Prevention
CHS-SHS	Second-Hand Smoke
CHS-SX	Sexuality
CHS-TO	Tobacco

CHA CHILD HEALTH ADOLESCENT (12-18 YEARS)

CHA-CD	Chemical Dependency
CHA-FU	Follow-up
CHA-GD	Growth and Development
CHA-L	Patient Information Literature
CHA-N	Nutrition
CHA-PA	Parenting
CHA-S	Safety and Injury Prevention
CHA-SHS	Second-Hand Smoke
CHA-SX	Sexuality
CHA-TO	Tobacco

CB CHILDBIRTH

CB-AP	Anatomy and Physiology
CB-C	Complications
CB-EX	Exercises, Relaxation & Breathing
CB-FU	Follow-up
CB-L	Literature
CB-LB	Labor Signs
CB-M	Medications
CB-OR	Orientation
CB-PM	Pain Management
CB-PRO	Procedures, Obstetrical
CB-RO	Role Of Labor And Delivery Partner/Coach

CKD CHRONIC KIDNEY DISEASE

CKD-AP	Anatomy and Physiology
CKD-C	Complications
CKD-DP	Disease Process
CKD – EQ	Equipment
CKD – LA	Lifestyle Adaptations
CKD - M	Medications
CKD - N	Nutrition
CKD-P	Prevention
CKD-PRO	Procedures
CKD-TE	Tests
CKD-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

CPM CHRONIC PAIN

CPM-DP	Disease Process
CPM-EX	Exercise
CPM-FU	Follow-Up
CPM-L	Patient Information Literature
CPM-LA	Lifestyle Adaptations
CPM-M	Medications
CPM-S	Safety

CDC COMMUNICABLE DISEASES

CDC-DP	Disease Process
CDC-FU	Follow-up
CDC-HM	Home Management
CDC-L	Patient Information Literature
CDC - M	Medication
CDC-N	Nutrition
CDC-P	Prevention
CDC-PM	Pain Management

CHF CONGESTIVE HEART FAILURE

CHF-C	Complications
CHF-DP	Disease Process
CHF-EX	Exercise
CHF-FU	Follow-up
CHF-HM	Home Management
CHF-L	Patient Information Literature
CHF-LA	Lifestyle Adaptations
CHF-M	Medications
CHF-N	Nutrition

CAD CORONARY ARTERY DISEASE

CAD-C	Complications
CAD-DP	Disease Process
CAD-EX	Exercise
CAD-FU	Follow-up
CAD-L	Patient Information Literature
CAD-LA	Lifestyle Adaptations
CAD-M	Medications
CAD-N	Nutrition
CAD-P	Prevention
CAD-PM	Pain Management
CAD-PRO	Procedures
CAD-TE	Tests
CAD-TX	Treatments

CRN CROHN'S DISEASE

CRN-C	Complications
CRN-DP	Disease Process
CRN-FU	Follow-up
CRN-L	Patient Information Literature
CRN-M	Medications
CRN-N	Nutrition
CRN-P	Prevention
CRN-PM	Pain Management
CRN-TE	Tests
CRN-TX	Treatment

CRP CROUP

CRP-C	Complications
CRP-DP	Disease Process
CRP-FU	Follow-up
CRP-HM	Home Management
CRP-L	Patient Information Literature
CRP-M	Medications
CRP-SHS	Second-Hand Smoke

CF CYSTIC FIBROSIS

CF-C	Complications
CF-DP	Disease Process
CF-EQ	Equipment
CF-FU	Follow-up
CF-L	Patient Literature Information
CF-N	Nutrition
CF-SHS	Second Hand Smoke
CF-TE	Tests
CF-TO	Tobacco (Smoking)
CF-TX	Treatment

DEH DEHYDRATION

DEH-C	Complications
DEH-DP	Disease Process
DEH-FU	Follow-up
DEH-L	Patient Information Literature
DEH-P	Prevention
DEH-TE	Tests
DEH-TX	Treatments

INDEX OF PATIENT EDUCATION PROTOCOLS

DC DENTAL CARIES

DC-AP	Anatomy and Physiology
DC-C	Complications
DC-DP	Disease Process
DC-FU	Follow-up
DC-L	Patient Information Literature
DC-N	Nutrition
DC-P	Prevention
DC-PM	Pain Management
DC-TE	Tests
DC-TX	Treatment

DM DIABETES MELLITUS

DM-C	Complications
DM-DP	Disease Process
DM-EQ	Equipment
DM-EX	Exercise
DM-FTC	Foot Care And Examinations
DM-FU	Follow-up
DM-HM	Home Management
DM-KID	Kidney Disease
DM-L	Patient Information Literature
DM-LA	Lifestyle Adaptations
DM-M	Medications
DM-N	Nutrition
DM-P	Prevention
DM-PM	Pain Management
DM-WC	Wound Care

DIA DIALYSIS

DIA-AP	Anatomy and Physiology
DIA-C	Complications
DIA-DP	Disease Process
DIA-EQ	Equipment
DIA-FU	Follow-up
DIA-L	Patient Information Literature
DIA-M	Medication
DIA-N	Nutrition
DIA-PRO	Procedures

SUP DIETARY SUPPLEMENTS

SUP-C	Complications
SUP-FU	Follow-up
SUP-I	Supplement Information
SUP-SCH	Schedule

DCH DISCHARGE FROM HOSPITAL

DCH-EQ	Equipment
DCH-FU	Follow-up
DCH-HM	Home Management
DCH-L	Patient Information Literature
DCH-LA	Lifestyle Adaptations
DCH-M	Medications
DCH-N	Nutrition
DCH-POC	Plan Of Care
DCH-PRO	Procedures
DCH-REF	Referral
DCH-RI	Patient Rights And Responsibilities
DCH-S	Safety
DCH-TE	Testing
DCH-TX	Treatment

DIV DIVERTICULITIS /DIVERTICULOSIS

DIV-C	Complications
DIV-DP	Disease Process
DIV-FU	Follow-up
DIV-L	Patient Information Literature
DIV-M	Medications
DIV-N	Nutrition
DIV-P	Prevention
DIV-PM	Pain Management
DIV-TE	Tests
DIV-TX	Treatment

DV DOMESTIC VIOLENCE

DV-DP	Disease Process
DV-FU	Follow-up
DV-L	Patient Information Literature
DV-P	Prevention
DV-PSY	Psychotherapy
DV-S	Safety and Injury Prevention
DV-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

LIP DYSLIPIDEMIAS

LIP-C	Complications
LIP-DP	Disease Process
LIP-EX	Exercise
LIP-FU	Follow-up
LIP-L	Patient Information Literature
LIP-LA	Lifestyle Adaptations
LIP-M	Medications
LIP-N	Nutrition
LIP-P	Prevention

DYS DYSRHYTHMIAS

DYS-C	Complications
DYS-DP	Disease Process
DYS-EQ	Equipment
DYS-FU	Follow-up
DYS-L	Patient Information Literature
DYS-M	Medications
DYS-TE	Tests
DYS-TX	Treatment

ECC EARLY CHILDHOOD CARIES

ECC-C	Complications
ECC-DP	Disease Process
ECC-FU	Follow-up
ECC-GD	Growth and Development
ECC-L	Patient Information Literature
ECC-LA	Lifestyle Adaptations
ECC-N	Nutrition
ECC-P	Prevention
ECC-PM	Pain Management
ECC-PRO	Procedures
ECC-TE	Tests
ECC-TX	Treatment

ECZ ECZEMA / ATOPIC DERMATITIS

ECZ-C	Complications
ECZ-DP	Disease Process
ECZ-FU	Follow-up
ECZ-L	Patient Information Literature
ECZ-M	Medications
ECZ-N	Nutrition
ECZ-P	Prevention
ECZ-WC	Wound Care

ELD ELDER CARE

ELD-DP	Disease Process/Aging
ELD-EX	Exercise
ELD-FU	Follow-up
ELD-L	Patient Information Literature
ELD-LA	Lifestyle Adaptations
ELD-M	Medications
ELD-N	Nutrition
ELD-S	Safety and Injury Prevention

EOL END OF LIFE

EOL-DP	Disease Process
EOL-EQ	Equipment
EOL-GP	Grieving Process
EOL-L	Patient Information Literature
EOL-LA	Lifestyle Adaptations
EOL-LW	Living Will
EOL-M	Medication
EOL-N	Nutrition
EOL-PM	Pain Management
EOL-PSY	Psychotherapy
EOL-TX	Treatment

EYE EYE CONDITIONS

EYE-AP	Anatomy and Physiology
EYE-C	Complications
EYE-DP	Disease Process
EYE-FU	Follow-up
EYE-HM	Home Management
EYE-L	Patient Information Literature
EYE-LA	Lifestyle Adaptations
EYE-M	Medications
EYE-P	Prevention
EYE-PM	Pain Management
EYE-TE	Tests
EYE-TX	Treatment

FALL FALL PREVENTION

FALL-C	Complications
FALL-DP	Disease Process
FALL-FU	Follow-up
FALL-L	Patient Information Literature
FALL-S	Safety and Injury Prevention

INDEX OF PATIENT EDUCATION PROTOCOLS

FP FAMILY PLANNING

FP-AP	Anatomy and Physiology
FP-DIA	Diaphragm
FP-DPO	Depot Medroxyprogesterone Injections
FP-FC	Foam And Condoms
FP-FU	Follow-up
FP-IC	Implant Contraception
FP-IUD	Intrauterine Device
FP-L	Patient Information Literature
FP-MT	Methods
FP-N	Nutrition
FP-OC	Oral Contraceptives
FP-ST	Sterilization

F FEVER

F-C	Complications
F-DP	Disease Process
F-FU	Follow-up
F-HM	Home Management
F-L	Patient Information Literature
F-M	Medications

FRST FROSTBITE

FRST-C	Complications
FRST-DP	Disease Process
FRST-FU	Follow-up
FRST-L	Patient Information Literature
FRST-M	Medications
FRST-N	Nutrition
FRST-P	Prevention
FRST-PM	Pain Management
FRST-TX	Treatment
FRST-WC	Wound Care

GB GALLBLADDER DISORDERS

GB-AP	Anatomy and Physiology
GB-C	Complications
GB-DP	Disease Process
GB-FU	Follow-up
GB-L	Literature
GB-M	Medications
GB-N	Nutrition
GB-P	Prevention
GB-PM	Pain Management
GB-PRO	Procedures
GB-TE	Tests

GE GASTROENTERITIS

GE-C	Complications
GE-DP	Disease Process
GE-FU	Follow-up
GE-HM	Home Management
GE-L	Patient Information Literature
GE-M	Medications
GE-N	Nutrition
GE-PM	Pain Management
GE-TE	Testing
GE-TX	Treatment

GER GASTROESOPHAGEAL REFLUX DISEASE

GER-DP	Disease Process
GER-FU	Follow-up
GER-L	Patient Information Literature
GER-LA	Lifestyle Adaptations
GER-M	Medications
GER-N	Nutrition
GER-PM	Pain Management
GER-TE	Tests
GER-TX	Treatment

GAD GENERALIZED ANXIETY DISORDER

GAD-C	Complications
GAD-DP	Disease Process
GAD-EX	Exercise
GAD-M	Medication
GAD-TX	Treatment

GIB GIBBLEED

GIB-C	Complications
GIB-DP	Disease Process
GIB -FU	Follow-up
GIB -L	Patient Information Literature
GIB -M	Medications
GIB -N	Nutrition
GIB -P	Prevention
GIB-TE	Tests
GIB-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

GL GLAUCOMA

GL-DP	Disease Process
GL-FU	Follow-up
GL-L	Patient Information Literature
GL-LT	Laser Therapy
GL-M	Medications

GBS GUILLAIN-BARRE SYNDROME

GBS-C	Complications
GBS-DP	Disease Process
GBS-FU	Follow-up
GBS-L	Patient Information Literature
GBS-LA	Lifestyle Adaptations
GBS-M	Medications
GBS-N	Nutrition
GBS-TE	Tests
GBS-TX	Treatments

HRA HEARING AIDS

HRA-EQ	Equipment
HRA-FU	Follow-up
HRA-L	Patient Information Literature
HRA-LA	Lifestyle Adaptations

HL HEARING LOSS

HL-DP	Disease Process
HL-EQ	Equipment
HL-FU	Follow-up
HL-L	Patient Information Literature
HL-SL	Speech And Language Screening
HL-TE	Testing

HEAT HEATSTROKE

HEAT-C	Complications
HEAT-DP	Disease Process
HEAT-EX	Exercise
HEAT-FU	Follow-up
HEAT-L	Patient Information Literature
HEAT-M	Medications
HEAT-N	Nutrition
HEAT-P	Prevention
HEAT-TX	Treatment

HEP HEPATITIS A,B,C

HEP-AP	Anatomy and Physiology
HEP-C	Complications
HEP-DPA	Disease Process Hepatitis A
HEP-DPB	Disease Process- Hepatitis B
HEP-DPC	Disease Process Hepatitis C
HEP-FU	Follow-up
HEP-L	Literature
HEP-LA	Lifestyle Adaptations
HEP-M	Medication
HEP-N	Nutrition
HEP-P	Prevention
HEP-TE	Testing
HEP-TX	Treatment

HIV HUMAN IMMUNODEFICIENCY VIRUS

HIV-C	Complications
HIV-DP	Disease Process
HIV-FU	Follow-up
HIV-HM	Home Management
HIV-HY	Hygiene
HIV-L	Patient Information Literature
HIV-LA	Lifestyle Adaptations
HIV-M	Medications
HIV-N	Nutrition
HIV-P	Prevention
HIV-PN	Prenatal
HIV-S	Safety
HIV-TE	Tests
HIV-TX	Treatment

HTN HYPERTENSION

HTN-C	Complications
HTN-DP	Disease Process
HTN-EQ	Equipment
HTN-EX	Exercise
HTN-FU	Follow-up
HTN-L	Patient Information Literature
HTN-LA	Lifestyle Adaptations
HTN-M	Medications
HTN-N	Nutrition

INDEX OF PATIENT EDUCATION PROTOCOLS

HTH HYPERTHYROIDISM

HTH-AP	Anatomy and Physiology
HTH-C	Complications
HTH-DP	Disease Process
HTH-FU	Follow-up
HTH-L	Patient Information Literature
HTH-M	Medications
HTH-N	Nutrition
HTH-TE	Tests
HTH-TX	Treatments

LTH HYPOTHYROIDISM

LTH-AP	Anatomy and Physiology
LTH-C	Complications
LTH-DP	Disease Process
LTH-EX	Exercise
LTH-FU	Follow-up
LTH-L	Patient Information Literature
LTH-LA	Lifestyle Adaptations
LTH-M	Medications
LTH-N	Nutrition
LTH-TE	Tests

IM IMMUNIZATION

IM-DEF	Deficiency
IM-FU	Follow-up
IM-I	Immunization Information
IM-L	Patient Information Literature
IM-P	Prevention
IM-SCH	Schedule

IGT IMPAIRED GLUCOSE

TOLERANCE

IGT-C	Complications
IGT-DP	Disease Process
IGT-EX	Exercise
IGT-FU	Follow-up
IGT-L	Patient Information Literature
IGT-LA	Lifestyle Adaptations
IGT-N	Nutrition
IGT-P	Prevention
IGT-TE	Tests

IMP IMPETIGO

IMP-DP	Disease Process
IMP-FU	Follow-up
IMP-L	Patient Information Literature
IMP-M	Medications
IMP-P	Prevention
IMP-TX	Treatment

FLU INFLUENZA

FLU-C	Complications
FLU-DP	Disease Process
FLU-FU	Follow-up
FLU-IM	Immunization
FLU-L	Patient Information Literature
FLU-M	Medications
FLU-N	Nutrition
FLU-P	Prevention

INJ INJURIES

INJ-CC	Cast Care
INJ-EQ	Equipment
INJ-EX	Exercise
INJ-FU	Follow-up
INJ-HM	Home Management
INJ-I	Information
INJ-L	Patient Information Literature
INJ-M	Medication
INJ-P	Prevention
INJ-PM	Pain Management
INJ-WC	Wound Care

LAB LABORATORY

LAB-DRAW	Phlebotomy
LAB-FU	Follow-up
LAB-L	Literature
LAB-S	Safety
LAB-TE	Tests

INDEX OF PATIENT EDUCATION PROTOCOLS

PB LEAD EXPOSURE/ LEAD

	<u>TOXICITY</u>
PB-C	Complications
PB-DP	Disease Process
PB-FU	Follow-up
PB-L	Patient Information Literature
PB-N	Nutrition
PB-P	Prevention
PB-SCR	Screening
PB-TE	Tests
PB-TX	Treatments

LIV LIVER

LIV – AP	Anatomy and Physiology
LIV – C	Complications:
LIV – DP	Disease Process
LIV – FU	Follow-up
LIV-L	Patient Information Literature
LIV-LA	Lifestyle Adaptations
LIV-M	Medications
LIV-N	Nutrition
LIV-TX	Treatment

DEP MAJOR DEPRESSION

DEP-DP	Disease Process
DEP-EX	Exercise
DEP-FU	Follow-up
DEP-L	Patient Information Literature
DEP-M	Medications
DEP-PSY	Psychotherapy
DEP-WL	Wellness

MEDS MEDICAL SAFETY

MEDS-C	Complications
MEDS-FU	Follow-up
MEDS-I	Information
MEDS-L	Patient Information Literature
MEDS-M	Medications
MEDS-P	Prevention
MEDS-TE	Tests

M MEDICATIONS

M-DI	Drug Interaction
M-FU	Follow-up
M-I	Information
M-L	Patient Information Literature
M-PRX	Medication Dispensation To Proxy

MPS MENOPAUSE

MPS-AP	Anatomy and Physiology
MPS-C	Complications
MPS-DP	Disease Process
MPS-EX	Exercise
MPS-FU	Follow-up
MPS-L	Literature
MPS-LA	Lifestyle Adaptations
MPS-M	Medications
MPS-N	Nutrition
MPS-PRO	Procedures
MPS-S	Safety and Injury Prevention

MH MEN'S HEALTH

MH-BE	Breast Exam
MH-FU	Follow-up
MH-HY	Hygiene
MH-L	Patient Information Literature
MH-M	Medications
MH-PRS	Prostate Health
MH-RS	Reproductive System
MH-TSE	Testicular Self-Exam

MSX METABOLIC SYNDROME

MSX-C	Complications
MSX-DP	Disease Process
MSX –EQ	Equipment
MSX-EX	Exercise
MSX-FU	Follow-up
MSX-L	Patient Information Literature
MSX-LA	Lifestyle Adaptations
MSX-M	Medications
MSX-N	Nutrition
MSX-P	Prevention
MSX-TE	Tests

INDEX OF PATIENT EDUCATION PROTOCOLS

NF NEONATAL FEVER

NF-C	Complications
NF-DP	Disease Process
NF-FU	Follow-up
NF-L	Patient Information Literature
NF-M	Medications
NF-P	Prevention
NF-TE	Testing

ND NEUROLOGIC DISORDER

ND-DP	Disease Process
ND-EQ	Equipment
ND-EX	Exercise
ND-FU	Follow-up
ND-L	Patient Information Literature
ND-LA	Lifestyle Adaptations
ND-M	Medications
ND-N	Nutrition
ND-PM	Pain Management
ND-S	Safety and Injury Prevention

OBS OBESITY

OBS-C	Complications
OBS-DP	Disease Process
OBS-EX	Exercise
OBS-FU	Follow-up
OBS-L	Patient Information Literature
OBS-LA	Lifestyle Adaptations
OBS-M	Medication
OBS-N	Nutrition
OBS-P	Prevention

ODM OCULAR DIABETES

ODM-C	Complications
ODM-DP	Disease Process
ODM-FU	Follow-up
ODM-L	Patient Information Literature
ODM-LA	Lifestyle Adaptations
ODM-LT	Laser Therapy
ODM-M	Medications
ODM-PM	Pain Management

OS OSTEOPOROSIS

OS-C	Complications
OS-DP	Disease Process
OS-EX	Exercise
OS-FU	Follow-up
OS-HM	Home Management
OS-L	Patient Information Literature
OS-M	Medication
OS-N	Nutrition
OS-P	Prevention
OS-PM	Pain Management
OS-TE	Tests
OS-TX	Treatment

OM OTITIS MEDIA

OM-C	Complications
OM-DP	Disease Process
OM-FU	Follow-up
OM-L	Patient Information Literature
OM-LA	Lifestyle Adaptations
OM-M	Medications
OM-P	Prevention
OM-PET	Pressure Equalization Tubes
OM-PM	Pain Management

PM PAIN MANAGEMENT

PM-AP	Anatomy and Physiology
PM-DP	Disease Process
PM-EX	Exercise
PM-FU	Follow-up
PM-L	Patient Information Literature
PM-LA	Lifestyle Adaptations
PM-M	Medication
PM-N	Nutrition
PM-P	Prevention
PM-PSY	Psychotherapy
PM-TE	Tests
PM-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

PC PANCREATITIS

PC-DP	Disease Process
PC-FU	Follow-up
PC-L	Literature
PC-M	Medications
PC-N	Nutrition
PC-P	Prevention
PC-PM	Pain Management
PC-TX	Treatment

PNL PERINATAL LOSS

PNL-C	Complications
PNL-DP	Disease Process
PNL-FU	Follow Up
PNL-GP	Grieving Process
PNL-L	Literature
PNL-M	Medications
PNL-N	Nutrition
PNL-PM	Pain Management
PNL-TX	Treatment

PD PERIODONTAL DISEASE

PD-AP	Anatomy and Physiology
PD-C	Complications
PD-DP	Disease Process
PD-FU	Follow-up
PD-L	Patient Information Literature
PD-M	Medications
PD-N	Nutrition
PD-P	Prevention
PD-PM	Pain Management
PD-TE	Tests
PD-TX	Treatment

PVD PERIPHERAL VASCULAR DISEASE

PVD-C	Complications
PVD-DP	Disease Process
PVD-FU	Follow-up
PVD-HM	Home Management
PVD-L	Patient Information Literature
PVD-LA	Lifestyle Adaptations
PVD-M	Medications
PVD-N	Nutrition
PVD-P	Prevention
PVD-PM	Pain Management
PVD-TE	Tests
PVD-TX	Treatments

PT PHYSICAL THERAPY

PT-EQ	Equipment
PT-EX	Exercise
PT-FU	Follow-up
PT-GT	Gait Training
PT-I	Information
PT-L	Patient Information Literature
PT-N	Nutrition
PT-TX	Treatment
PT-WC	Wound Care

PNM PNEUMONIA

PNM-C	Complications
PNM-DP	Disease Process
PNM-EX	Exercise
PNM-FU	Follow-up
PNM-IS	Incentive Spirometry
PNM-L	Patient Information Literature
PNM-M	Medications
PNM-N	Nutrition
PNM-P	Prevention
PNM-PM	Pain Management
PNM-TE	Tests
PNM-TX	Treatment

POI POISONING

POI-FU	Follow-up
POI-I	Information
POI-L	Patient Information Literature
POI-P	Prevention
POI-TE	Tests
POI-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

PP POSTPARTUM

PP-C	Complications
PP-FU	Follow-up
PP-I	Information
PP-KE	Kegel Exercise
PP-L	Patient Information Literature
PP- M	Medications
PP-PM	Pain Management
PP-WC	Wound Care

PDEP POSTPARTUM DEPRESSION

PDEP-DP	Disease Process
PDEP-FU	Follow-up
PDEP-L	Patient Information Literature
PDEP-LA	Lifestyle Adaptations
PDEP-M	Medications
PDEP-N	Nutrition
PDEP-TX	Treatment

PN PRENATAL

PN-1T	First Trimester
PN-2T	Second Trimester
PN-3T	Third Trimester
PN-BH	Behavioral Health
PN-C	Complications
PN-CD	Chemical Dependency
PN-DC	Dental Caries
PN-DV	Domestic Violence
PN-FU	Follow-up
PN-GDM	Gestational Diabetes
PN-GEN	Genetic Testing
PN-HIV	Human Immunodeficiency Virus
PN-L	Patient Information Literature
PN - M	Medications
PN-N	Nutrition
PN-PIH	Pregnancy Induced Hypertension And Pre- Eclampsia
PN-PM	Pain Management
PN-S	Safety and Injury Prevention
PN-SHS	Second-Hand Smoke
PN-SOC	Social Health
PN-STD	Sexually Transmitted Disease
PN-TO	Tobacco

PL PULMONARY DISEASE

PL-BIP	Bilevel (Or Continuous) Positive Airway Pressure Ventilation
PL-C	Complications
PL-DP	Disease Process
PL-EX	Exercise
PL-FU	Follow-up
PL-HM	Home Management
PL-INT	Intubation
PL-IS	Incentive Spirometry
PL-L	Patient Information Literature
PL-LA	Lifestyle Adaptations
PL-M	Medications
PL-MDI	Metered-Dose Inhalers
PL-N	Nutrition
PL-NEB	Nebulizer
PL-O2	Oxygen Therapy
PL-PF	Peak-Flow Meter
PL-PM	Pain Management
PL-PRO	Procedures
PL-SHS	Second-Hand Smoke
PL-SPA	Spacers
PL-TO	Tobacco (Smoking)
PL-VENT	Mechanical Ventilation

XRAY RADIOLOGY/NUCLEAR MEDICINE

XRAY-C	Complications
XRAY-FU	Follow-up
XRAY-L	Literature
XRAY-M	Medications
XRAY-PRO	Procedure
XRAY-S	Safety
XRAY-TE	Tests

INDEX OF PATIENT EDUCATION PROTOCOLS

RSV RESPIRATORY SYNCYTIAL

VIRUS

RSV-C	Complications
RSV-DP	Disease Process
RSV-FU	Follow-up
RSV-HM	Home Management
RSV-L	Patient Information Literature
RSV-M	Medications
RSV-NEB	Nebulizer
RSV-P	Prevention
RSV-SHS	Second-Hand Smoke
RSV-TE	Testing
RSV-TO	Tobacco (Smoking)

RST RESTRAINTS

RST-EQ	Equipment
RST-L	Patient Information Literature
RST-M	Medications
RST-S	Safety and Injury Prevention

RD RHEUMATIC DISEASE

RD-C	Complications
RD-DP	Disease Process
RD-EX	Exercise
RD-FU	Follow-up
RD-L	Patient Information Literature
RD-LA	Lifestyle Adaptations
RD-M	Medications
RD-N	Nutrition
RD-PM	Pain Management

SZ SEIZURE DISORDER

SZ-C	Complications
SZ-DP	Disease Process
SZ-FU	Follow-up
SZ-L	Patient Information Literature
SZ-LA	Lifestyle Adaptations
SZ-M	Medications
SZ-S	Safety and Injury Prevention

SARS SEVERE ACUTE

RESPIRATORY SYNDROME

SARS-C	Complications
SARS-DP	Disease Process
SARS-FU	Follow-up
SARS-HM	Home Management
SARS-HY	Hygiene
SARS-L	Patient Information Literature
SARS-LA	Lifestyle Adaptations
SARS-M	Medications
SARS-P	Prevention
SARS-TE	Testing
SARS-TX	Treatment

STD SEXUALLY TRANSMITTED DISEASES

STD-C	Complications
STD-FU	Follow-up
STD-I	Information
STD-L	Patient Information Literature
STD-M	Medication
STD-P	Prevention
STD-TE	Testing
STD-TX	Treatment

SWI SKIN AND WOUND INFECTIONS

SWI-C	Complications
SWI-DP	Disease Process
SWI-FU	Follow-up
SWI-L	Patient Information Literature
SWI-M	Medication
SWI-P	Prevention
SWI-WC	Wound Care

ST STREP THROAT

ST-C	Complications
ST-DP	Disease Process
ST-FU	Follow-up
ST-L	Patient Information Literature
ST-M	Medications
ST-P	Prevention
ST-PM	Pain Management
ST-TE	Tests

INDEX OF PATIENT EDUCATION PROTOCOLS

SIDS SUDDEN INFANT DEATH

SYNDROME

SIDS-I	Information
SIDS-L	Patient Information Literature
SIDS-P	Prevention
SIDS-S	Safety and Injury Prevention
SIDS-SHS	Second-Hand Smoke

SB SUICIDAL BEHAVIOR

SB-FU	Follow-up
SB-L	Patient Information Literature
SB-PSY	Psychotherapy
SB-TX	Treatment
SB-WL	Wellness

SPE SURGICAL PROCEDURES AND

ENDOSCOPY

SPE-C	Complications
SPE-FU	Follow-up
SPE-L	Patient Information Literature
SPE-PM	Pain Management
SPE-PO	Postoperative
SPE-PR	Preoperative
SPE-PRO	Procedures
SPE-WC	Wound Care

TO TOBACCO USE

TO-C	Complications
TO-DP	Disease Process
TO-EX	Exercise
TO-FU	Follow-up
TO-L	Patient Information Literature
TO-LA	Lifestyle Adaptations
TO-M	Medications
TO-QT	Quit
TO-SHS	Second-Hand Smoke

TB TUBERCULOSIS

TB-DOT	Directly Observed Therapy
TB-DP	Disease Process
TB-FU	Follow-up
TB-L	Patient Information Literature
TB-M	Medications
TB-P	Prevention
TB-PPD	Screening Skin Test

UC ULCERATIVE COLITIS

UC-C	Complications
UC-DP	Disease Process
UC-FU	Follow-up
UC-L	Patient Information Literature
UC-M	Medications
UC-N	Nutrition
UC-P	Prevention
UC-PM	Pain Management
UC-TE	Tests
UC-TX	Treatment

URI UPPER RESPIRATORY

INFECTION

URI-DP	Disease Process
URI-FU	Follow-up
URI-HM	Home Management
URI-L	Patient Information Literature
URI-M	Medications
URI-P	Prevention

UTI URINARY TRACT INFECTION

UTI-AP	Anatomy and Physiology
UTI-DP	Disease Process
UTI-FU	Follow-up
UTI-HY	Hygiene
UTI-L	Patient Information Literature
UTI-M	Medication
UTI-N	Nutrition
UTI-P	Prevention
UTI-PM	Pain Management
UTI-TE	Tests

WL WELLNESS

WL-EX	Exercise
WL-FU	Follow-up
WL-HY	Hygiene
WL-L	Patient Information Literature
WL-LA	Lifestyle Adaptations
WL-N	Nutrition
WL-S	Safety and Injury Prevention
WL-SCR	Screening
WL-SX	Sexuality

INDEX OF PATIENT EDUCATION PROTOCOLS

WH WOMEN'S HEALTH

WH-BE	Breast Exam	WH-OS	Osteoporosis
WH-FU	Follow-up	WH-PAP	Pap Smear
WH-HY	Hygiene	WH-PMS	Premenstrual Syndrome
WH-KE	Kegel Exercise	WH-PRO	Procedures
WH-L	Patient Information Literature	WH-RS	Reproductive System
WH-MP	Menopause	WH-STD	Sexually Transmitted Diseases (Refer to Codes For STD)
WH-MS	Menses	WH-TE	Tests
WH-N	Nutrition		

DIABETES CURRICULUM EDUCATION

DMC-ABC	Knowing Your Numbers (ABC)	DMC-MSE	Mind, Spirit And Emotion
DMC-AC	Acute Complications	DMC-N	Nutrition (Basics Of Healthy Eating)
DMC-BG	Behavioral Goals (Making Healthy Changes)	DMC-PPC	Pre-Pregnancy Counseling
DMC-BGM	Blood Sugar Monitoring, Home	GDM GESTATIONAL DIABETES	
DMC-CC	Chronic Complications (Preventing and treating diabetes complication)	GDM-BG	Behavioral Goals (Making Healthy Changes)
DMC-DP	Disease Process (What Is Diabetes)	GDM-BGM	Blood Sugar Monitoring, Home
DMC-EX	Exercise (Moving to Stay Healthy)	GDM-C	Complications
DMC-FTC	Foot Care (Taking Care of Your Feet)	GDM-DP	Disease Process
DMC-M	Diabetes Medicine- Overview and Diabetes Pills	GDM-EX	Exercise (Physical Activity and Pregnancy)
DMC-IN	Diabetes Medicine - Insulin	GDM-FU	Follow-up
		GDM-L	Patient Information Literature
		GDM-N	Nutrition (Meal Planning in Pregnancy)

GENERAL EDUCATION TOPICS

AP - Anatomy and Physiology	M - Medications
C - Complications	N - Nutrition
DP - Disease Process	P - Prevention
EQ - Equipment	PRO - Procedures
EX - Exercise	S - Safety
FU - Follow-up	TE - Testing
HM - Home Management	TX - Treatment
HY - Hygiene	MNT-Medical Nutrition Therapy (For Use By Registered Dieticians Only)
L - Patient Information Literature	
LA - Lifestyle Adaptations	

INDEX OF PATIENT EDUCATION PROTOCOLS

EDUCATION NEEDS ASSESSMENT CODES

BAR-BLND	Blind	LP-GP	Small Group
BAR-COGI	Cognitive Impairment	LP-READ	Read
BAR-DEAF	Deaf	LP-TALK	Talk
BAR-DNRE	Doesn't Read	LP-VIDO	Video
BAR-EMOI	Emotional Impairment	RL-DSTR	Distraction
BAR-FIMS	Fine Motor Skills Deficit	RL – EAGR	Eager To Learn
BAR-HEAR	Hard Of Hearing	RL – RCPT	Receptive
BAR-INTN	Interpreter Needed	RL-PAIN	PAIN
BAR – NONE	No Barriers	RL-SVIL	Severity of Illness
BAR-STRS	Social Stressors	RL-UNRC	Unreceptive
BAR-VALU	Values/Belief		
BAR-VISI	Visually Impaired		
LP-DOIT	Do/Practice		