

INDIAN HEALTH SERVICE

**Patient and Family Education
Protocols and Codes
(PEPC)**

**SURGERY & ANESTHESIA
CODES**

**11th Edition
January 2005**

FOREWORD TO THE 11TH EDITION OF THE PATIENT EDUCATION PROTOCOLS

FOREWORD

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

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

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

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FOREWORD TO THE 11TH EDITION OF THE PATIENT EDUCATION PROTOCOLS

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Use and Documentation of Patient Education Codes

Why Use the Codes?

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

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

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

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

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

SOAP Charting and the Codes

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

How to Use the Codes

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

The educator should document the education using the following steps:

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

USE AND DOCUMENTATION OF PATIENT EDUCATION CODES

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

OBJECTIVE	DEFINITION	MNEMONIC
Goal Set	<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

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

Recording the Patient's Response to Education

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

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

USE AND DOCUMENTATION OF PATIENT EDUCATION CODES

IHS-303 (10/95)
PL 16-811 N.A.

PCC AMBULATORY ENCOUNTER RECORD

Date _____

Arrival Time _____ AM _____ PM

Clinic _____

Appt. _____ Walk-in _____

PROBLEM LIST UPDATE
(Enter Problem Numbers From Health Summary)

Remove _____ Move to Inactive _____ Move to Active _____

PROVIDERS

INITIALS / CODE

XYZ

TEMP _____ PULSE _____ RESP _____

BP _____

WT _____

HT _____

HEAD _____

VISION - UNCORRECTED _____

VISION - CORRECTED _____

INITIALS _____

CM
 NS
 LB-OZ

CM
 IN

CM
 IN

CM
 IN

CM
 IN

CHIEF COMPLAINT _____

SUBJECTIVE/OBJECTIVE _____

Injury? Yes No If yes, Date: _____ ETOH Related Employ. Rel.

Cause: _____ Place: _____

(For additional Documentation, see IHS 45-3 Continuation Sheet)

OTHER TESTS/PROCEDURES ORDERED

Health Factors

STS

GC

PAP

Pulv

Breast

Mammogram

Rectal

Chest X-ray

PURPOSE OF VISIT (PRINT ONLY IN THIS SECTION; DO NOT ABBREVIATE)

Learning Preference - TALK
HTN - N - G - XYZ - 5 min - GS, patient will reduce salt intake

REPRODUCTIVE FACTORS: G _____ P _____ LC _____ S _____ LM _____

PROBLEM LIST NOTED: STORE NOTE FOR PROB. # _____

STORE NOTE FOR PROB. # _____

MEDICATIONS _____

MEDICATIONS / TREATMENTS / PROCEDURES / PATIENT EDUCATION

Learning Preference - TALK
HTN - N - G - XYZ - 5 min - GS, patient will reduce salt intake

DATE BEGUN _____ REMOVE NOTE # _____

DATE _____ TIME _____

HR # _____ SSN # _____

NAME _____

B DATE _____ SEX _____

RESIDENCE _____

FACILITY _____

REFERRAL TO: _____

PURPOSE: _____

INSTRUCTIONS TO PATIENT: _____

SIGN RELEASE RECORDS

DATE _____

TYPE OF DESKTOP: Making Straightforward

COMPLEXITY: Low Moderate High

Signature

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

USE AND DOCUMENTATION OF PATIENT EDUCATION CODES

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

IHS-367 (4/94)		PCC GROUP PREVENTIVE SERVICES				P.L. 98-511 N.A.
DATE		PROVIDER CODE		PROVIDER CODE		SERVICES PROVIDED
LOCATION		APR	DR	INITIALS/Code	APR	
INITIALS/Code		INITIALS/Code		INITIALS/Code		
LAST NAME	FIRST	SEX	HEALTH RECORD NUMBER	SPECIFIC SERVICES PROVIDED - INCLUDE RESULTS AS APPROPRIATE		
				OBS-EX-GP-30 min.-XYZ-GS: Add 30 minutes of exercise to daily routine*		
In this column, ask participants to write their name.		In this column, ask participants to write their sex, Male or Female (M or F)		* This "education string" documents that education was provided on Obesity and the importance of exercise; in a Group setting; duration of the educational encounter was for 30 minutes; by Provider XYZ; and all participants agreed to set a goal of adding 30 minutes of exercise to their daily routine.		
		In this column, ask patients to write in their hospital/clinic chart number, if they know this information. If not, such as children in a classroom, ask them to write their birthdate.				
This completed form can be used by PHNs, CHRs, Health Educators, physicians, dental hygienists, Diabetes Educators, etc., to document and capture information about educational activities in the community/schools/or work sites. The completed form must be taken to Medical Records so that the information can be entered into the RPMS system.						
DIRECTIONS				PROVIDER SIGNATURE		
This form is used to record services provided in group settings for entry into the PCC. Examples include blood pressure, vision, and hearing screenings; selected lab test results; PPD readings; and group education sessions where assessment of individual patient understanding is determined. Patients should be individually identified in the columns above and the individual services provided indicated for each patient. Different types of service can be recorded on a single form and multiple services may be recorded for individual patients.						

USE AND DOCUMENTATION OF PATIENT EDUCATION CODES

<p style="text-align: center;">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>
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<p>LEARNING PREFERENCES (LP Code) Assessed Yearly If Assessed Today, Today's Date:</p>	<p>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:

<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

List measures taken to address above barriers:

Comments: _____

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

Patient Identification **Providers please sign on back of form**

Reimbursement for Patient Education

Preventive Medicine Services

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

Reimbursement for Patient Education

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

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

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

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

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

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

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

REIMBURSEMENT FOR PATIENT EDUCATION

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

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

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

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

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

Documentation Requirements:

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

Coordination of Care

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

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

REIMBURSEMENT FOR PATIENT EDUCATION

Important Aspects concerning Reimbursement for PATIENT EDUCATION

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

Documentation of Evaluation and Management (E/M) Services

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

BRIEF Sample - Office Visits, Established Patients

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

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

REIMBURSEMENT FOR PATIENT EDUCATION

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

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

REIMBURSEMENT FOR PATIENT EDUCATION

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

REIMBURSEMENT FOR PATIENT EDUCATION

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

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

General Education Codes

Guidelines For Use

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

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

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

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

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

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

For example:

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

Head lice - TX - G - <provider initials>7 min. – GS: Pt. will wash bed linens

Impetigo - M, FU - G - <provider initials>GS: Pt. will practice good hygiene by not sharing items.

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

Head lice - prevention - poor understanding10 min. – GS: Pt. will wash bed linens

Head lice - treatment - good understanding 7 min. – GS: Pt. will wash bed linens

Impetigo - medications, follow-up - good understanding: Pt. will practice good hygiene by not sharing items.

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

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

General Education Topics

AP - ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

C - COMPLICATIONS

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

STANDARDS:

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

DP - DISEASE PROCESS

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

STANDARDS:

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

EQ - EQUIPMENT

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

STANDARDS:

1. Discuss indications for and benefits of prescribed home medical equipment.
2. Discuss types and features of home medical equipment as appropriate.
3. Discuss and/or demonstrate proper use and care of home medical equipment, participate in return demonstration by patient/family.
4. Discuss signs of equipment malfunction and proper action in case of malfunction.
5. Emphasize safe use of equipment, i.e., no smoking around 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 understand the relationship of physical activity to this disease state, condition or to health promotion and disease prevention and develop a plan to achieve an appropriate activity level.

STANDARDS:

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

FU - FOLLOW-UP

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

STANDARDS:

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

HM - HOME MANAGEMENT

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

STANDARDS:

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

HY - HYGIENE

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

STANDARDS:

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

L - PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

LA - LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

M - MEDICATIONS

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

STANDARDS:

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

N - NUTRITION

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

STANDARDS:

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

P - PREVENTION

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

STANDARDS:

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

PRO - PROCEDURES

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

STANDARDS:

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

S - SAFETY

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

STANDARDS:

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

TE - TESTS

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

STANDARDS:

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

TX - TREATMENT

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

STANDARDS:

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

MNT—Medical Nutrition Therapy

****For Use By Registered Dietitians Only****

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

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

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

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

EDUCATION NEEDS ASSESSMENT CODES

INDIAN HEALTH SERVICE EDUCATION NEEDS ASSESSMENT CODES

BAR—Barriers to Learning

BAR-BLND BLIND

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

STANDARDS:

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

BAR-COGI COGNITIVE IMPAIRMENT

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

STANDARDS:

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

BAR-DEAF DEAF

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

STANDARDS:

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

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

BAR-DNRE DOESN'T READ

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

STANDARDS:

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

BAR-EMOI EMOTIONAL IMPAIRMENT

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

STANDARDS:

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

BAR-FIMS FINE MOTOR SKILLS DEFICIT

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

STANDARDS:

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

BAR-HEAR HARD OF HEARING

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

STANDARDS:

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

BAR-INTN INTERPRETER NEEDED

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

STANDARDS:

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

BAR – NONE NO BARRIERS

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

STANDARDS:

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

BAR-STRS SOCIAL STRESSORS

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

STANDARDS:

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

BAR-VALU VALUES/BELIEF

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

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

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

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

STANDARDS:

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

BAR-VISI VISUALLY IMPAIRED

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

STANDARDS:

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

LP—Learning Preference

LP-DOIT DO/PRACTICE

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

STANDARDS:

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

LP-GP SMALL GROUP

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

STANDARDS:

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

LP-READ READ

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

STANDARDS:

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

LP-TALK TALK

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

STANDARDS:

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

LP-VIDEO VIDEO

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

STANDARDS:

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

RL—Readiness to Learn

RL-DSTR DISTRACTION

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

STANDARDS:

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

RL – EAGR EAGER TO LEARN

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

STANDARDS:

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

RL – RCPT RECEPTIVE

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

STANDARDS:

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

RL-PAIN PAIN

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

STANDARDS:

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

RL-SVIL SEVERITY OF ILLNESS

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

STANDARDS:

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

RL-UNRC UNRECEPTIVE

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

STANDARDS:

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

A**ABD—Abdominal Pain****ABD-C COMPLICATIONS**

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

STANDARDS:

1. Explain that some possible complications are acute hemorrhage, sustained hypotension and shock, perforation of a 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 participation to the medication regimen.
3. Encourage the patient to carry a list of current medications.

ABD-N NUTRITION

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

STANDARDS:

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

ABD-PM PAIN MANAGEMENT

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

STANDARD:

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

ABD-SM STRESS MANAGEMENT

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

STANDARDS:

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

ABD-TE TESTS

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

STANDARDS:

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

ABD-TX TREATMENT

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

STANDARDS:

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

ADV—Advance Directives

ADV-I INFORMATION

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

STANDARDS:

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

ADV-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

ADV-LW LIVING WILL

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

STANDARDS:

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

ADV-POA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

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

STANDARDS:

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

ADV-RI PATIENT RIGHTS AND RESPONSIBILITIES

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

STANDARDS:

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

AN—Anemia

AN-C **COMPLICATIONS**

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

STANDARDS:

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

AN-DP DISEASE PROCESS

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

STANDARDS:

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

AN-FU FOLLOW-UP

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

STANDARDS:

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

AN-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

AN-M MEDICATIONS

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

STANDARDS:

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

AN-N NUTRITION

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

STANDARDS:

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

AN-PRO PROCEDURES

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

STANDARDS:

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

AN-TE TESTS

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

STANDARDS:

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

AN-TX TREATMENTS

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

STANDARDS:

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

ANS—Anesthesia

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 understand 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 have a basic understanding of endotracheal intubation, as well as the risks, benefits, alternatives to endotracheal intubation and associated factors affecting the patient.

STANDARDS:

1. Explain the basic procedure for endotracheal intubation, including the risks and benefits of endotracheal intubation and the adverse events which might result from refusal.
2. Discuss alternatives to endotracheal intubation, including expectant management, as appropriate.
3. Explain that the patient will be unable to speak or eat while intubated.

ANS-IS INCENTIVE SPIROMETRY

OUTCOME: The patient will understand the reason for use of the incentive spirometer and demonstrate appropriate use.

STANDARDS:

1. Explain that regular and appropriate use of the incentive spirometer according to instructions reduces the risk of respiratory complications including pneumonia.
2. Explain that the optimal body position for incentive spirometry is semi-Fowler's position which allows for free movement of the diaphragm.
3. Instruct the patient to exhale normally and evenly inhale maximally through the spirometer mouthpiece.
4. Encourage the patient to hold the maximal inspiration for a minimum of three seconds to allow for redistribution of gas and opening of atelectatic areas.
5. Instruct the patient to exhale slowly and breathe normally between maneuvers.
6. Instruct the patient to repeat this maneuver as frequently as prescribed.

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 understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient; and may be multifaceted. **Refer to [PM](#).**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Explain non-pharmacologic measures that may be helpful with pain control.

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/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.

ANS-PRO PROCEDURES

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

STANDARDS:

1. Explain the proposed procedure (such as spinals, epidurals, intrathecal, and regional blocks) and how it relates to effective anesthesia.
2. Explain the specific procedure(s) to be performed, including the risks and benefits of performing the procedure, as well as the risks and benefits of refusing the procedure.
3. Discuss alternatives to the proposed procedure(s), including expectant management, as appropriate.
4. Discuss the expected patient/family involvement in the care required following the proposed procedure(s).

ANS-TCB TURN, COUGH, DEEP BREATH

OUTCOME: The patient/family will understand why it is important to turn, cough and deep breath and the patient will be able to demonstrate appropriate deep breathing and coughing.

STANDARDS:

1. Explain that it is important to frequently (every 1 to 2 hours) turn, cough and breath deeply to prevent complications such as pneumonia after a surgical procedure. Explain that turning prevents stasis of secretions and breathing deeply and coughing helps to mobilize and clear secretions and keep small airways open.
2. Describe appropriate deep breathing and coughing (take a large breath and hold it for 3 – 5 seconds, exhale and cough shortly 2 to 3 times).
3. Demonstrate appropriate splinting techniques (e.g., using a pillow held tightly to the abdomen over the surgical site).
4. Have the patient return a demonstration of appropriate deep breathing, coughing, and splinting.

B**BL—Blood Transfusions****BL-C COMPLICATIONS**

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

STANDARDS:

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

BL-EQ EQUIPMENT

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

STANDARDS:

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

BL-FU FOLLOW-UP

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

STANDARDS:

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

BL-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

BL-S SAFETY

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

STANDARDS:

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

BL-TE TESTS

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

STANDARDS:

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

BL-TX TREATMENT

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

STANDARDS:

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

BURN—Burns

BURN-C COMPLICATIONS

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

STANDARDS:

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

BURN-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

BURN-DP DISEASE PROCESS

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

STANDARDS:

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

BURN-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

BURN-P PREVENTION

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

STANDARDS:

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

- (3) Use cool water humidifiers not steam vaporizers
 - (4) Before putting a child into a car seat, touch the seat to check how hot it is. It is a good idea to keep a towel covering the car seat in summer months.
 - (5) When cooking, turn the handles of pots toward the side or rear of the stove, don't wear loose clothing that can come in contact with the stove. You should always use the back burners first.
 - (6) Use extreme caution when lifting lids from pots as steam may suddenly be released
 - (7) Use caution when removing items in a microwave as they may be very hot. Use only microwave approved dishware.
- d. To prevent electrical burns:
- (1) Put covers on any electrical outlets not currently in use.
 - (2) Don't use items with frayed or damaged electrical cords.
 - (3) Don't overload outlets
 - (4) Keep electrical devices away from water and use ground fault circuit interrupter outlets near water sources
 - (5) Don't modify electrical cords or plugs
 - (6) Use power surge protectors
6. Review the dangers inherent in the use of wood-burning stoves, "charcoal pans", kerosene heaters, and other open flames.
 7. Encourage the use and proper maintenance of smoke detectors, carbon monoxide detectors, and fire suppression systems.
 8. Encourage routine practices of fire escape plans, chimney cleaning, and fireworks safety.
 9. Review the safe use of electricity and natural gas.
 10. Avoid the use of kerosene or gasoline when burning debris piles.

BURN-TX TREATMENT

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

STANDARDS:

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

BURN -WC WOUND CARE

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

STANDARDS:

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

C**CA—Cancer****CA-AP ANATOMY AND PHYSIOLOGY**

OUTCOME: The patient/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-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

CA-DP DISEASE PROCESS

OUTCOME: The patient/family/caregiver will understand 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/family will understand 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 fully participating in 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/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/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 full participation 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/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 understand the 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/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, i.e., PAP smears, colonoscopy, BSE, TSE, PSA.
6. Emphasize the importance of early detection of cancer in cancer cure. Encourage the patient to come in early if signs of cancer (i.e., 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) are detected.

CA-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 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-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress can result in a worsened prognosis in cancer patients.
2. Explain that effective stress management may help reduce the morbidity and mortality associated with cancer, as well as help improve the patient's sense of health and well-being.
3. Discuss various stress management strategies such as maintaining a healthy lifestyle. Some examples may include:
 - a. becoming aware of your own reactions to stress
 - b. recognizing and accepting your limits
 - c. talking with people you trust about your worries or problems
 - d. setting realistic goals
 - e. getting enough sleep
 - f. maintaining a reasonable diet
 - g. exercising regularly
 - h. taking vacations
 - i. practicing meditation
 - j. self-hypnosis
 - k. using positive imagery
 - l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
 - m. spiritual or cultural activities
4. Provide referrals as appropriate.

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.

CPM—Chronic Pain

CPM-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

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-EQ EQUIPMENT

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

STANDARDS:

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

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-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.

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, i.e., remove throw rugs, install bars in the tub/shower.
3. Stress importance and proper use of mobility devices, i.e., cane, walker, wheel chair.

CPM-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress may exacerbate the symptoms of chronic pain. This can set up a cycle of pain-stress which becomes self-sustaining and may escalate.
2. Explain that uncontrolled stress can interfere with the treatment of chronic pain.
3. Discuss that in chronic pain, uncontrolled stress may lead to depression or other mood disorders. **Refer to [CPM-PSY](#).**
4. Explain that effective stress management may reduce the severity of symptoms the patient experiences, as well as help improve the health and well-being of the patient.
5. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the severity of pain.
6. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
 - a. becoming aware of your own reactions to stress
 - b. recognizing and accepting your limits
 - c. talking with people you trust about your worries or problems
 - d. setting realistic goals
 - e. getting enough sleep
 - f. maintaining a reasonable diet
 - g. exercising regularly
 - h. taking vacations
 - i. practicing meditation
 - j. self-hypnosis
 - k. using positive imagery
 - l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
 - m. spiritual or cultural activities
7. Provide referrals as appropriate.

CPM-TE TESTS

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

STANDARDS:

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

CPM-TX TREATMENT

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

STANDARDS:

1. Discuss with the patient/family the possible appropriate nonpharmacologic pain relief measures, i.e., TENS units, heat, cold, massage, meditation, imagery, acupuncture, healing touch, traditional healer, hypnosis.
2. Discuss with the patient/family the possible appropriate pharmacologic pain relief measures. **Refer to [CPM-M](#).**
3. Discuss with the patient/family the possible appropriate procedural or operative pain management techniques, i.e., nerve block, intrathecal narcotics, local anesthesia.
4. Emphasize the importance of the patient/family's full participation in the development of a treatment plan.
5. As appropriate, discuss the implications of patient-provider contracts for pain medications.

CRN—Crohn's Disease

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-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

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 understand how dietary modification may assist in the control of bowel function and develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.
2. 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 understand 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 fully participate 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-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in Crohn's disease.

STANDARDS:

1. Explain that uncontrolled stress can increase constipation or diarrhea, abdominal pain, and fatigue.
2. Explain that uncontrolled stress can interfere with the treatment of Crohn's disease.
3. Explain that effective stress management may reduce the adverse consequences of Crohn's disease, as well as help improve the health and well-being of the patient.
4. Explain that stress may cause inappropriate eating which will exacerbate the symptoms of Crohn's disease. **Refer to [CRN-N](#).**
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
 - a. becoming aware of your own reactions to stress
 - b. recognizing and accepting your limits
 - c. talking with people you trust about your worries or problems
 - d. setting realistic goals
 - e. getting enough sleep
 - f. maintaining a reasonable diet
 - g. exercising regularly
 - h. taking vacations
 - i. practicing meditation
 - j. self-hypnosis
 - k. using positive imagery
 - l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
 - m. spiritual or cultural activities
6. Provide referrals as appropriate.

CRN-TE TESTS

OUTCOME: The patient/family will understand 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 understand the appropriate treatment for bowel disease and have a plan to fully participate in 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.

D**DIV—Diverticulitis / Diverticulosis****DIV-C COMPLICATIONS**

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

STANDARDS:

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

DIV-DP DISEASE PROCESS

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

STANDARDS:

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

DIV-FU FOLLOW-UP

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

STANDARDS:

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

DIV-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

DIV-M MEDICATIONS

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

STANDARDS:

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

DIV-N NUTRITION

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

STANDARDS:

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

DIV-P PREVENTION

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

STANDARDS:

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

DIV-PM PAIN MANAGEMENT

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

STANDARDS:

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

DIV-TE TESTS

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

STANDARDS:

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

DIV-TX TREATMENT

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

STANDARDS:

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

DYS—Dysrhythmias

DYS-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

DYS-C COMPLICATIONS

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

STANDARDS:

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

DYS-DP DISEASE PROCESS

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

STANDARDS:

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

DYS-EQ EQUIPMENT

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

STANDARDS:

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

DYS-FU FOLLOW-UP

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

STANDARDS:

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

DYS-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

DYS-M MEDICATIONS

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

STANDARDS:

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

DYS-PRO PROCEDURES

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

STANDARDS:

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

DYS-TE TESTS

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

STANDARDS:

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

DYS-TX TREATMENT

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

STANDARDS:

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

F**F—Fever****F-C COMPLICATIONS**

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

STANDARDS:

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

F-DP DISEASE PROCESS

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

STANDARDS:

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

F-EQ EQUIPMENT

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

STANDARDS:

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

F-FU FOLLOW-UP

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

STANDARDS:

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

F-HM HOME MANAGEMENT

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

STANDARDS:

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

F-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

F-M MEDICATIONS

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

STANDARDS:

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

F-TE TESTS

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

STANDARDS:

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

FRST—Frostbite

FRST-C COMPLICATIONS

OUTCOME: The patient and/or family will understand the consequences of frostbite; and the complications associated with frostbite.

STANDARDS:

1. Explain that the severity of frostbite is associated with how deep the freeze is. No tissue is safe. This can involve the skin layers as well as the fat, muscle, blood vessels, lymphatics, nerves and even the bones.
2. Discuss that frostbite is just like receiving a burn; and is categorized based upon the extent of the tissue injury.
 - a. First Degree: is a partial freeze of the skin. Clinical Appearance: Redness, swelling, possible peeling of skin about a week later. Symptoms: Periodic burning, stinging, aching, throbbing; excessive sweating in the area.
 - b. Second Degree: All layers of the skin have frozen. Clinical Appearance: Redness, significant swelling, blisters, black scabs, Symptoms: Numbness, heaviness of the affected area.
 - c. Third Degree: Skin and subcutaneous tissues are completely frozen. Clinical Appearance: Purplish blisters (blood-filled), dusky blue skin discoloration, death of the skin. Symptoms: Loss of sensation, area feels like “wood”. Later on, the area has significant burning and throbbing.
 - d. Fourth Degree: Complete involvement of skin, fat, muscle, bone. Clinical Appearance: Minimal swelling. The area is initially quite red, then becomes black. Symptoms: Occasional joint pain.
3. Emphasize the importance to avoid thawing and then refreezing the injury. This is very dangerous and can cause serious sequella.

FRST-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

FRST-DP DISEASE PROCESS

OUTCOME: The patient and/or family will understand how frostbite occurs the signs and symptoms of frostbite, and risk factors associated with frostbite.

STANDARDS:

1. Explain that frostbite, simply defined, is the freezing of the skin and/or the bodily tissues under the skin.
2. Discuss signs and symptoms of frostbite with the patient/family:
 - a. Mild frostbite (frostnip) affects the outer skin layers and appears as a blanching or whitening of the skin.
 - b. Severe frostbite: the skin will appear waxy-looking with a white, grayish-yellow or grayish-blue color.
 - c. Affected body parts will have no feeling (numbness) and blisters may be present.
 - d. The tissue will feel frozen or “wooden”.
 - e. Other symptoms include swelling, itching, burning and deep pain as the area is warmed.
3. Discuss the pathophysiology of frostbite: the fluids in the body tissues and cellular spaces freeze and crystallize. This can cause damage to the blood vessels and result in blood clotting and lack of oxygen to the affected area.
4. Review with patient/family predisposing conditions to frostbite:
 - a. exposure of the body to cold
 - b. length of time a person is exposed to the cold
 - c. temperature outside
 - d. wind-chill factor
 - e. humidity in the air
 - f. wetness of clothing and shoes
 - g. ingestion of alcohol and other drug
 - h. high altitudes
5. Explain that frostbite can occur in a matter of minutes.
6. Discuss with patient/family that the most common parts of the body affected by frostbite include the hands, feet, ears, nose and face.
7. Review with patient/family the medical conditions that make some at greater risk for frostbite:
 - a. the elderly and young
 - b. persons with circulation problems
 - c. history of previous cold injuries
 - d. ingestion of particular drugs, i.e., alcohol, nicotine and beta-blockers
 - e. persons from southern/tropical climates exposed to cold weather conditions.

FRST-FU FOLLOW-UP

OUTCOME: The patient and/or family will understand the seriousness of frostbite and the importance of follow up care.

STANDARDS:

1. Discuss the importance of follow up appointments after frostbite to determine if there is any permanent or ongoing damage.
2. Discuss the importance of keeping follow up appointments.
3. Discuss the procedures for obtaining follow up appointments.

FRST-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient and/or family will receive written information about frostbite, and important preventive measures.

STANDARDS:

1. Provide patient/family with written information on frostbite and prevention of frostbite.
2. Discuss the content of frostbite written information with the patient/family.

FRST-M MEDICATIONS

OUTCOME: The patient/family will understand the use of medications to manage frostbite.

STANDARDS:

1. Explain to patient/family that the blistered areas may require topical medications applied during dressing changes as prescribed by provider.
2. Discuss appropriate medications available for acute and chronic pain.
3. Advise patient/family that a tetanus vaccination is necessary if not received in last 5-10 years.
4. Discuss the common and important side effects and drug interactions of medications prescribed.

FRST-N NUTRITION

OUTCOME: The patient/family will understand the nutritional problems associated with frostbite.

STANDARDS:

1. Discuss that based on severity of the injury the need for replenishment of calories, fluids, protein, nitrogen and other nutrients may be essential.
2. Refer to a registered dietician as appropriate.

FRST-P PREVENTION

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

STANDARDS:

1. Discuss with the patient/family that the majority of frostbite cases are preventable, and that it is easier to prevent frostbite than to treat it.
2. Emphasize the importance of keeping clothing/socks dry. Wet clothing predisposes to frostbite.
3. Explain that it is important to minimize wind exposure. Wind proof clothing can be helpful. High winds increase heat loss from the body.
4. Discuss that it is important to wear loose, layered clothing (i.e., hat, gloves, loosely fitting layered clothing). Constrictive clothing increases the likelihood of frostbite as does immobilization and dependency of the extremities. Proper clothing for winter weather insulates from the cold, lets perspiration evaporate and provides protection against wind, rain and snow. Wear several layers of light, loose clothing that will trap air, yet provide adequate ventilation. This is better protection than one bulky or heavy covering.
5. Discuss the importance to stocking the vehicle appropriately for winter travel (i.e., blankets, gloves, hats).
6. Discuss that when in frostbite-causing conditions, dressing appropriately, staying near adequate shelter and remaining physically active can significantly reduce the risk of suffering from frostbite.
7. Discuss the importance of avoiding alcohol, and other drugs while participating in outdoor activities.
8. Review the sensations associated with overexposure to cold, i.e., sensations of intermittent stinging, burning, throbbing and aching are all early signs of frostbite. Get indoors.
9. Discuss with patient/family the medical conditions that make some at greater risk for frostbite:
 - a. the elderly and young
 - b. persons with circulation problems
 - c. history of previous cold injuries
 - d. ingestion of particular drugs, i.e., alcohol, nicotine and beta-blockers
 - e. persons from southern/tropical climates exposed to cold weather conditions.

FRST-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand how to manage the pain associated with the acute and chronic tissue damage caused from frostbite.

STANDARDS:

1. Discuss that there has been some evidence that aloe vera in a 70% concentration when applied topically may be helpful in pain management.
2. Discuss appropriate pain management plan with patient/family.

FRST-TX TREATMENT

OUTCOME: The patient and/or family will understand the management and treatment of frostbite.

STANDARDS:

1. Discuss the goal of treatment with the patient; prevention of further exposure to affected area(s), and management and prevention of complications.
2. Emphasize the need to have frostbite injuries rewarmed under medical supervision.
3. Explain that the patient needs to get to a warm place where he/she can stay warm after thawing. Refreezing can cause more severe tissue damage.
4. Review proper thawing process:
 - a. Use warm-to-the touch water 100° F (38° C.) For 30-45 minutes until a good color (flush) has returned to the entire area. Emphasize that this process may be painful, especially the final few minutes.
 - b. Leave the blisters intact. Cover with a sterile or clean covering if protection is needed to prevent rupturing of blisters.
 - c. Keep the affected part(s) as clean as possible to reduce the risk of infection.
 - d. Keep the affected area elevated above the level of the heart.
5. Emphasize the importance of having a current tetanus booster (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 understand the necessity and procedure for proper wound care.

STANDARDS:

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

G**GB—Gallbladder****GB-AP ANATOMY AND PHYSIOLOGY**

OUTCOME: The patient will have a basic understanding of where the gallbladder is in the body and its function in digestion.

STANDARDS:

1. Discuss that the gallbladder is a small bag found under the liver.
2. Explain that the function of a normal gallbladder is to store bile, concentrate it by removing water and empty this concentrated bile into the intestine when fatty foods are eaten.
3. Explain that the gallbladder empties through the cystic duct into the common bile duct which then empties into the small intestine. Explain that the common bile duct also drains the liver and the pancreas.
4. Explain that the bile helps to digest the fat in the foods.

GB-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of untreated or progressed gallbladder disease. (Please choose from the following standards as they apply to this patient's specific disease process.)

STANDARDS:

1. Explain that if the amount of bile and other chemicals inside the gallbladder get out of balance gallstones can form. Most gallstones are cholesterol gallstones and form when too much cholesterol is secreted into the gallbladder from the liver.
2. Explain that gallstones usually don't cause a problem if they stay in the gallbladder. Approximately 80% of people with gallstones have no symptoms at all.
3. Explain that sometimes gallstones move into the ducts that drain the gallbladder and that this may lead to pain, infections, diseases of the liver, disease of the pancreas and may lead to gangrene or perforation of the gallbladder.
4. Empyema of the gallbladder (pus in the gallbladder) is a serious complication of acute cholecystitis and can result in death in about 25% of cases. Empyema is relatively rare, however, it does occur in about 2% of cases of acute cholecystitis.
5. Explain that patients with choledocholithiasis (stones in the common bile ducts) may get cholangitis (infection of the bile ducts). This is very serious and may be treated with antibiotics and may require surgery. Choledocholithiasis may also result in pancreatitis. **Refer to [PC](#).**
6. Explain that risk of serious complications can be reduced by seeking prompt medical attention.

GB-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the causes and symptoms of his/her gallbladder disease. (Please choose from the following standards as they apply to this particular patient.)

STANDARDS:

1. Explain that gallstones (cholelithiasis) can cause problems when a gallstone gets lodged in either the cystic duct or the common bile duct. This can result in right upper quadrant abdominal pain, nausea, vomiting, heartburn and back pain.
2. Explain that gallstones in the common bile duct can also result in jaundice or pancreatitis. This condition is called choledocholithiasis.
3. Explain that biliary colic is a mild form of gallbladder disease and results in right upper quadrant abdominal pain several hours after eating a fatty meal. The pain is not relieved by changes in position, over-the-counter medications or passing gas. It will usually spontaneously resolve in 1-5 hours.
4. Explain that acute cholecystitis is similar to biliary colic but is more severe. It results from inflammation of the gallbladder. Infection is often present. The pain with cholecystitis is more severe and often patients complain of pain with breathing. This is a severe condition which can progress to perforation of the gallbladder or gangrene. Patients with acute 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 fully participating in the treatment regimen and make a plan for appropriate follow-up.

STANDARDS:

1. Discuss the individual's responsibility in the management of gallbladder disease.
2. Review the treatment plan with the patient, emphasizing the importance for follow-up care.
3. Discuss the procedure for obtaining follow-up appointments.

GB-L LITERATURE

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

STANDARDS:

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

GB-M MEDICATIONS

OUTCOME: The patient/family will understand the medications to be used in the management of gallbladder disease.

STANDARDS:

1. Explain as indicated that some medications may be used to dissolve small gallstones.
2. Explain the regimen to be implemented in pain control as indicated.
3. Explain the medications to be used in this patient including the dosage, timing, proper use and storage of the medication, important and common side-effects of the medication including drug-drug and drug-food interactions.

GB-N NUTRITION

OUTCOME: The patient/family will understand ways diet relates to gallbladder disease.

STANDARDS:

1. Explain that a diet that is high in fat and simple sugars can contribute to the formation of gallstones.
2. Explain that rapid weight loss should be avoided as it may contribute to formation of gallstones. Encourage overweight persons to undertake a rational approach to weight loss that includes exercise and moderate dietary limitation under the consultation of a physician.

GB-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of gallbladder disease.

STANDARDS:

1. Explain that maintaining a normal body weight and avoiding fasts are keys to reducing the risk of gallstones.
2. Explain that a low fat diet will help prevent gallbladder disease.
3. Explain that regular vigorous exercise reduces the risk of gallbladder disease. Exercises that seem most helpful are brisk walking, jogging, and racquet sports.

GB-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that pain management in gallbladder disease is specific to the disease process of this particular patient and may be multifaceted.
2. Explain that often antispasmodics may be helpful.
3. Explain that short term use of narcotics may be helpful in pain management.
4. Explain that other medications may be helpful to control the symptoms of nausea and vomiting.
5. Explain that administration of fluids may help with pain relief and resolution of symptoms.
6. **Refer to [PM](#).**

GB-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure(s) as well as risks, benefits and alternatives to the proposed procedure(s). **Refer to [SPE](#).**

STANDARDS:

1. Explain the specific procedure to be performed including the risks and benefits both of doing the procedure and adverse events which might result from refusal of the procedure.
2. Discuss alternatives to the proposed procedure including expectant management, as appropriate.

GB-TE TESTS

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

STANDARDS:

1. Explain the test to be performed including the potential benefit to the patient and any adverse effects of the test or adverse effects which might result from refusal of the test.
2. Explain the testing process to help the patient understand what he/she might experience during the test.
3. Explain any preparation the patient may need to do for the proposed test, i.e., NPO status.

GER—Gastroesophageal Reflux Disease

GER-DP DISEASE PROCESS

OUTCOME: The patient will understand the anatomy and pathophysiology of gastroesophageal reflux disease.

STANDARDS:

1. Explain the anatomy and physiology of the esophagus and stomach.
2. Explain the process of acid reflux into the esophagus.
3. Explain how and why stomach acid reflux into the esophagus causes pain and disease.
4. Explain long-term complications of untreated GERD including carcinoma of the esophagus.

GER-FU FOLLOW-UP

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

STANDARDS:

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

GER-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about gastroesophageal reflux disease.

STANDARDS:

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

GER-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient and/or family will understand how to control GERD through lifestyle adaptation.

STANDARDS:

1. Emphasize the importance of tobacco cessation and decreased alcohol consumption.
2. Identify obesity as a major exacerbating factor in GERD. Discuss the importance of regular exercise and its role in obtaining and maintaining desirable weight.
3. Identify foods that may aggravate GERD.
4. Review the effect of timing of meals, i.e., no large meals before bedtime, more frequent light meals instead of few large meals.
5. Discuss physical control measures such as elevating the head of the bed.

GER-M MEDICATIONS

OUTCOMES: The patient/family will understand the medication, dosage and side effects that may occur. Patient/family will understand how the medication works to prevent the symptoms of GERD.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication..
2. Explain how the medication works to prevent the symptoms of GERD.
3. Explain that non-pharmacologic therapies in combination with medications will help reduce the symptoms of GERD.
4. Emphasize the importance of possible drug interactions with foods and over the counter medications.

GER-N NUTRITION

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

STANDARDS:

1. Review normal nutritional needs for optimal health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss nutritional modifications as related to Gastroesophageal Reflux Disease.
4. Emphasize the importance of fully participating in the prescribed nutritional plan.

GER-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to [PM](#).**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Explain non-pharmacologic measures that may be helpful with pain control.

GER-SM STRESS MANAGEMENT

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

STANDARDS:

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

GER-TE TESTS

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

STANDARDS:

1. Upper gastrointestinal barium studies.
2. Explain that the upper GI barium study is an x-ray to assess the degree and extent of the disease.
3. Explain that barium liquid will be swallowed and radiographs taken.
4. Discuss NPO status as indicated.
5. Discuss the test(s) for H. Pylori and how testing may assist in diagnosis and treatment.
6. Discuss as appropriate the procedure for EGD and the risks and benefits of performing this test. **Refer to [SPE](#).**

GER-TX TREATMENT

OUTCOME: The patient and/or family will understand the medical and surgical treatments available for GERD.

STANDARDS:

1. Discuss the use, benefits, and common side effects of the patient's prescribed medications.
2. Discuss possible surgical interventions for GERD as appropriate.

GIB—GI Bleed

GIB-C COMPLICATIONS

OUTCOME: The patient/family will understand the seriousness of gastrointestinal bleeding and will verbalize intent to obtain treatment if symptoms occur.

STANDARDS:

1. Explain that severe blood volume depletion and anemia can result from untreated gastrointestinal bleeding.
2. Explain that complications may be prevented with prompt treatment.
3. Discuss the symptoms of gastrointestinal bleeding, e.g. vomiting blood or coffee-ground emesis or black, tarry or bloody stools.

GIB-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

GIB-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the etiology and pathophysiology of their gastrointestinal disease.

STANDARDS:

1. Explain that gastrointestinal bleeding may have a variety of causes e.g. esophagitis, gastritis, peptic ulcers, esophageal varices, Crohn's disease, polyps, ulcerative colitis, diverticulosis or cancer.
2. Explain that the bleeding may present itself in a variety of ways, depending on the source and severity of the bleeding.
3. Explain that massive bleeding may result in weakness, dizziness, faintness, shortness of breath, crampy abdominal pain, diarrhea, or death.

GIB-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment, as appropriate.
3. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
4. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
5. Emphasize the importance of not tampering with any medical device.

GIB-FU FOLLOW-UP

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

STANDARDS:

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

GIB -L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the disease process involved with the gastrointestinal bleeding.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding the disease process involved with the gastrointestinal bleeding.
2. Discuss the content of the patient information literature with the patient/family.

GIB -M MEDICATIONS

OUTCOME: The patient will verbally summarize the prescribed medication regimen and the importance of full participation .

STANDARDS:

1. Review the proper use, benefits and common side effects of prescribed medications.
2. Discuss the use of antacids and medications to decrease acid production. Stress that absence of symptoms does not mean that the medication is no longer needed.
3. Stress the importance of avoiding substances containing aspirin, alcohol, nonsteroidal anti-inflammatory drugs, ibuprofen, and steroids, which might aggravate or precipitate further bleeding.
4. Discuss the importance of full participation with the medication regimen in order to promote healing and assure optimal comfort.

GIB –N NUTRITION

OUTCOME: The patient/family will understand the prescribed diet.

STANDARDS:

1. Explain that rest of the gastrointestinal tract may be required in the immediate GI bleed period.
2. Explain that IV nutrition support may be necessary if prolonged abstinence from food is required.
3. Explain that certain foods are likely to exacerbate the GI condition and should be avoided, i.e., alcohol, caffeine, fatty foods
4. Explain that gradual introduction of oral nutrients will be accomplished while decreasing IV nutrition support. Bowel irregularity is common during this period of time.
5. Explain that bland starchy foods are easier to digest and may be more easily tolerated.
6. Discuss that consumption of yogurt (with live or active cultures) is often helpful to resume normal bowel flora.

GIB –P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of gastrointestinal bleeding episodes.

STANDARDS:

1. Stress the importance of avoiding substances containing aspirin, alcohol nonsteroidal anti-inflammatory drugs, ibuprofen, and steroids, which might aggravate or precipitate bleeding.
2. Emphasize the importance of bowel regular bowel movements in the prevention of GI bleeds.

GIB-TE TESTS

OUTCOME: The patient/family will understand the diagnostic tests to be performed, the risk(s) and benefits of the proposed test as well as the risk(s) of non-performance of the test(s).

STANDARDS:

1. Explain that examining-a stool sample for occult blood is a simple and reliable method for determining subtle bleeding in the GI tract.
2. Explain that the cause of the bleeding may be found by directly visualizing the inside of the GI tract via an endoscope, a tube that is passed either by the mouth or the rectum.
3. Explain that sometimes defects of the GI tract that cause bleeding may be detected by x-ray by performing either a barium swallow or upper GI series or a barium enema.
4. Explain that the preparation for many of these procedures require that nothing be taken by mouth for several hours before the procedure, and enemas are usually required for the lower GI tests.
5. Explain that local anesthetics and sedation are usually given prior to the endoscopic procedures.

GIB-TX TREATMENT

OUTCOME: The patient/family will understand the appropriate management of the gastrointestinal bleeding.

STANDARDS:

1. Explain that IV fluids and/or blood transfusions may be necessary to replace lost blood volume. **Refer to [BL](#).**
2. Explain that for upper GI bleeding, gastric lavage may be necessary to remove the blood from the GI tract and prevent further complications.
3. Explain that electrocoagulation or photocoagulation (laser) may be necessary to stop the bleeding.
4. Explain that surgery may be necessary to resect the bleeding area or tumor if other measures are not effective.

H**HA—Headaches****HA-AP ANATOMY AND PHYSIOLOGY**

OUTCOME: The patient/family will understand the basic the AP of their particular type of headache.

STANDARDS:

1. Explain that headaches are multifactorial and the pathophysiology is dependant on the disease process.
2. Discuss the pathophysiogoly and related anatomy of this patient disease process.

HA-C COMPLICATIONS

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

STANDARDS

1. Discuss the possible complications, including:
 - a. Depression or other mood disorders
 - b. Suicidal behaviors
 - c. Domestic violence
 - d. Substance abuse
 - e. Substance use
 - f. Employment problems.
 - g. Relationship problems
 - h. Cognitive difficulties
 - i. Appetite change
 - j. Sensitivity to light and noise
 - k. Alteration in sleep patterns

HA-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the headache pain symptoms, type (migraine, tension, sinus, or cluster) and the causes if known.

STANDARDS:

1. Explain that the patient is the primary source of information about the pain's location, quality, intensity, onset, precipitating, or aggravating factors, frequency of headache pain and the measures that bring relief.
2. Discuss the current knowledge of this patient's type of headache.
3. Emphasize the importance of communicating information about the headache to the provider.
4. Discuss that the patient's presentation of symptoms is a unique combination of the type of pain, individual experiences and sociocultural adaptive responses.
5. Explain that headache pain may act as a warning sign of some problems in the body, including:
 - a. Sinus problems
 - b. Dehydration
 - c. Decayed teeth
 - d. Problems with eyes, ears, nose or throat
 - e. Infections and fever
 - f. Injury to the head
 - g. Physical or emotional fatigue
 - h. Exposure to toxic chemicals
 - i. High blood pressure
 - j. Sleep apnea
 - k. Mood disorders
 - l. Caffeine withdrawal (i.e., coffee, chocolate, tea, soft drinks)
 - m. Hangovers
 - n. Tumor (extremely rare)
6. Emphasize that influencing factors from internal and external changes are present. Some of these factors include:

Internal Factors:

Hormonal changes
Stress
Change in sleep habit

External Factors:

Weather changes
Alcohol
Bright /flickering light

HA-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.
4. Discuss important warning signs that would indicate earlier follow up is needed, including:
 - a. If the headache keeps you from your usual activities
 - b. If the headache lasts more than one day
 - c. If you have fever, stiff neck, nausea, or vomiting
 - d. If you feel drowsy or want to go to sleep
 - e. If you have had a recent head injury
 - f. If you develop eye pain, blurred vision, or trouble seeing
 - g. If you suspect the headache was caused by medicines
 - h. If you have persistent headaches seen by doctor
 - i. If the headache was the result of a head injury
 - j. If you have difficulty speaking
 - k. If you develop numbness or weakness of the arms or legs
 - l. If the headaches increase in intensity or frequency over time
 - m. If you experience instantaneous onset of severe headache
 - n. If the headaches require the daily use of pain-reliever medications
 - o. If the headache is experienced by very young children (preschool age)
 - p. If there is new onset headaches in middle-aged people.

HA-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

HA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle changes necessary to optimize performance of everyday activities and promote well-being.

STANDARDS:

1. Explain that treatment of headache pain is very individualized and may involve lifestyle adaptation, i.e., medication, rest and relaxation, exercise, stress-reduction, and/or internal or external changes.
2. Explain that exercise and social involvement (i.e., familial, traditional, cultural) may decrease the sense of pain and the depression and anger associated with pain.
3. Review lifestyle areas that may require adaptations, i.e., diet, substance use, rest and sleep patterns, physical activity, sexual activity, role changes, communication skills and interpersonal relationships.
4. Discuss lifestyle changes in relation to headache style.
5. Discuss techniques that may reduce stress and depression, such as meditation, maintaining regular sleep patterns, exercise program, hobbies and crafts, acupuncture, spiritual and cultural activities, or biofeedback training.
6. Refer to community resources as appropriate.

HA-M MEDICATION

OUTCOME: The patient/family will understand their medication regimen and the importance of fully participating with the therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications.
2. Discuss that there are many medications for the treatment or prevention of headaches and that narcotics are usually not indicated.
3. Explain that excess sedation and euphoria are not goals of palliative pharmacotherapy.
4. Emphasize that headache pain is not always completely understood and it is often necessary to take prophylactic medicines to assure optimal comfort levels. It is important to take preventive medication exactly as prescribed to prevent or reduce pain.
5. Discuss patient/family concerns about addiction. Explain the difference between psychological addiction and physical dependence upon prescribed medications. Reinforce that addiction is psychological dependence on a drug and is not equivalent to tolerance or physical dependence.
6. Emphasize the importance of consulting with provider before taking any OTC or herbal/traditional remedies.
7. Discuss the use of adjunct medications, if indicated, to control analgesic side effects, i.e., anti-emetics, laxatives, antacids.

HA-N NUTRITION

OUTCOME: The patient/family will understand the important contribution of healthy food choices and an adequate fluid intake in the treatment of headaches. They will be able to identify some dietary factors that may affect their headaches.

STANDARDS:

1. Assess eating habits.
2. Stress that eating regularly and not skipping meals is important.
3. Emphasize the necessary component – water – in a healthy diet.
4. Explain that constipation is a common side effect of some pain medications. Dietary measures such as increased water, increased fiber, increased fruit and decreased intake of milk products may be helpful.
5. Refer to dietitian or other local resources as indicated.

HA-P PREVENTION

OUTCOME: The patient/family will understand that headaches have varying etiologies and the mechanisms are not known for many headaches. The patient/family will identify the precipitating factors, if known, and develop a plan to maximize prevention strategies.

STANDARDS:

1. Discuss strategies for identifying headache triggers (i.e., journal, activity and food log).
2. Stress the importance of avoiding any known triggers.
3. Discuss that prophylactic medications must be taken as directed to be effective.
4. Emphasize that headaches seem to be more common during stressful times.

Refer to [HA-SM](#).

HA-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand that grief reactions and mood disorders are common with chronic headaches.

STANDARDS:

1. Discuss symptoms of mood disorders that may need additional professional support, sympathy, time, attention, compassion, and communication for patient/family.
2. Explain that if anti-depressant drugs are prescribed by the provider, full participation with the treatment plan is important to maximize the effectiveness of the treatment.
3. Explain that many mechanisms for dealing with grief and depression are available, i.e., support groups, individual therapy, family counseling, spiritual guidance.
4. Refer to community resources as appropriate.

HA-SM STRESS MANAGEMENT

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

STANDARDS:

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

HA-TE TESTS

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

STANDARDS:

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

HA-TX TREATMENT

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

STANDARDS:

1. Discuss with the patient/family the possible appropriate noninvasive pain relief measures, i.e., massage, heat, cold, rest, over-the-counter medications, books or tapes for relaxation.
2. Discuss with the patient/family the possible alternative pain relief measures, when appropriate, i.e., meditation, imagery, acupuncture, healing touch traditional healer, biofeedback, hypnosis.
3. Discuss with the patient/family the possible appropriate pharmacotherapy. **Refer to [HA-M](#).**
4. Discuss with the patient/family other possible approaches, i.e., lifestyle changes, physical therapy, nutritional changes, stress management, or psychotherapy.
5. Emphasize the importance of the patient/family's active involvement in the development of a treatment plan.

HTN—Hypertension

HTN-C COMPLICATIONS

OUTCOME: The patient will understand the complications of uncontrolled hypertension.

STANDARDS:

1. Explain that arteriosclerosis and atherosclerosis impede blood flow through the circulatory system.
2. Explain that heart attacks may result from the heart having to work harder to pump blood through congested and hardened arteries.
3. Explain that blindness may result from injured blood vessels in the eye.
4. Explain that strokes may result from ruptures of injured blood vessels in the brain.
5. Explain that circulatory complications eventually impair the ability of the kidneys to filter out toxins.

HTN-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

HTN-DP DISEASE PROCESS

OUTCOME: The patient will understand hypertension and summarize its causes.

STANDARDS:

1. Explain the difference between systolic and diastolic pressure. Define the normal ranges.
2. Review causative factors:
 - a. Lifestyle Factors: Obesity, high sodium intake, high fat and cholesterol intake, lack of regular exercise
 - b. Special Conditions: Pregnancy, oral contraceptives
 - c. Disease States: Diabetes, hyperthyroidism
 - d. Personal Factors: Family history, sex, race.
3. Discuss that most hypertension is asymptomatic, but some patients may experience headache, dizziness, faintness, nosebleed, or ringing in the ears and any of these symptoms should prompt immediate re-evaluation by a physician.

HTN-EQ EQUIPMENT

OUTCOME: The patient/family will receive information on the use of home blood pressure monitors.

STANDARDS:

1. Provide the patient/family with information on the use of the specific home blood pressure monitor.
2. Discuss the use of blood pressure monitoring equipment in public places, i.e., stores.
3. Discuss when to contact a health care provider for a blood pressure value which is outside the patient's personal guidelines.

HTN-EX EXERCISE

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

STANDARDS:

1. Explain how regular exercise helps to reduce high blood pressure and maintain normal blood pressure.
2. Discuss activity allowances and expectations (heavy lifting may predispose to complications).
3. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
 - a. 30 minutes 5 days per week
 - b. 15 minutes bouts 2 times a day 5 days per week
 - c. 10 minutes bouts 3 times a day 5 days per week
4. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
5. Assist the patient in developing a personal exercise plan. **Refer to [WL-EX](#).**
6. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
7. Discuss medical clearance issues for physical activity.

HTN-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the individual's responsibility in the management of hypertension.
2. Encourage regular blood pressure and weight checks.
3. Review treatment plan with the patient, emphasizing the need to keep appointments, take medication as directed, make indicated lifestyle changes, and control co-morbid conditions.

HTN-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

HTN-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle adjustments necessary to maintain control of blood pressure and develop a plan to modify his/her risk factors.

STANDARDS:

1. Emphasize the importance of weight control.
2. Discuss the importance of a program of regular exercise.
3. Discuss the relationship of stress to hypertension. Suggest ways of reducing stress—napping, meditation, exercise and “just relaxing.”
4. Explain that use of tobacco, either smoking or use of smokeless tobacco, can worsen hypertension and increase the risk of complications.

HTN-M MEDICATIONS

OUTCOME: If on medication, the patient will verbally summarize their medication regimen and the importance of full participation with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications.
2. Explain the importance of avoiding over-the-counter medications without checking with a physician.

HTN-N NUTRITION

OUTCOME: The patient will verbally summarize methods for control of blood pressure through weight control and diet modification.

STANDARDS:

1. Explain the role of salt intake in hypertension and ways to decrease salt intake:
 - a. Remove the salt shaker from the table
 - b. Taste food before salting
 - c. Discuss other seasonings
 - d. Read food labels to determine sodium content.
2. Discuss caffeine and its role in hypertension.
3. Discuss the importance of weight loss in controlling hypertension. **Refer to [WL-N](#).**
4. Encourage adequate intake of fruits, vegetables, water and fiber.

HTN-SM STRESS MANAGEMENT

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

STANDARDS:

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

HTN-TE TESTS

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

STANDARDS:

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

I

INJ—Injuries

INJ-CC CAST CARE

OUTCOME: The patient/family will understand the treatment plan and then importance of proper cast care.

STANDARDS:

1. Explain the reasons to care appropriately for the cast to improve healing.
2. Emphasize the importance of not placing foreign objects into the cast.
3. Explain the signs or symptoms that would prompt immediate follow-up, i.e., increased swelling, numbness, discoloration, increased pain.
4. Emphasize the importance of follow-up.

INJ-EQ EQUIPMENT

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

STANDARDS:

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

INJ-EX EXERCISE

OUTCOME: The patient/family will understand the exercises recommended or restricted as a result of this injury.

STANDARDS:

1. Discuss exercise recommendations or restrictions as they relate to the patient's injury.

INJ-FU FOLLOW-UP

OUTCOME: The patient/family will understand the treatment plan and the importance of making and keeping follow-up appointments.

STANDARDS:

1. Explain the recommended schedule for follow-up.
2. Explain the mechanism for obtaining follow-up.

INJ-HM HOME MANAGEMENT

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

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer falls, fewer emergency room visits, fewer hospitalizations and fewer complications.

INJ-I INFORMATION

OUTCOME: The patient/family will understand the pathophysiology of the patient's specific injury and recognize symptoms indicating a worsening of the condition.

STANDARDS:

1. Discuss the patient's specific injury, including anatomy and pathophysiology as appropriate.
2. Discuss the treatment plan and any indicated home management.
3. Discuss signs/symptoms of worsening of the condition and when to seek medical care.

INJ-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about their specific injury.

STANDARDS:

1. Provide the patient/family with written information about the patient's injury.
2. Discuss the content of the patient information literature with the patient/family.

INJ-M MEDICATION

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

STANDARDS:

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

INJ-P PREVENTION

OUTCOME: The patient/family will understand mechanisms to prevent occurrence of similar injuries in the future.

STANDARDS:

1. Discuss safety measures which may be implemented to prevent the occurrence of a similar injury in the future.
2. Refer to [WL-S](#).

INJ-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. Refer to [PM](#)
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Explain non-pharmacologic measures that may be helpful with pain control.

INJ-TE TESTS

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

STANDARDS:

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

INJ-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, i.e., decreased infection rate, improved healing.
2. Explain the correct procedure for caring for this patient's wound.
3. Explain signs or symptoms that should prompt immediate follow-up; increasing redness, purulent discharge, fever, increased swelling/pain, etc.
4. Detail the supplies necessary for the care of this wound (if any) and how/where they might be obtained.
5. Emphasize the importance of follow-up.

L**LAB—Laboratory****LAB-DRAW PHLEBOTOMY**

OUTCOME: The patient/family will understand the phlebotomy procedure.

STANDARDS:

1. Discuss the method of phlebotomy to be used for this lab draw.
2. Discuss common and important side effects or consequences of phlebotomy.

LAB-FU FOLLOW-UP

OUTCOME: The patient/family will understand the conditions that would require follow-up and how to obtain follow-up.

STANDARDS:

1. Discuss the findings that will signify a serious complication or condition.
2. Discuss the procedure for obtaining follow-up appointments.

LAB-L LITERATURE

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

STANDARDS:

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

LAB-S SAFETY

OUTCOME: Explain the procedure used to protect the patient and staff.

STANDARDS:

1. Discuss the use of personal protective equipment (i.e., gloves) and their role in preventing transmission of disease to the patient and the staff.
2. Discuss that needles and other lab draw equipment are single patient use and will be discarded after this draw.
3. Discuss the procedure for accidental needle-stick of the patient or the staff as appropriate.

LAB-TE TESTS

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

STANDARDS:

1. Explain the test that has been ordered.
2. Explain the necessity, benefits, and risks of the test to be performed. Refer to the primary provider as necessary.
3. Explain any necessary preparation for the test, i.e., fasting.
4. Explain the procedure for obtaining test results.
5. If the patient will obtain the specimen explain the procedure for properly obtaining the specimen and the storage of the specimen until it is returned to the lab.

O**OBS—Obesity****OBS-C COMPLICATIONS**

OUTCOME: The patient will be able to name at least 2 complications of obesity.

STANDARDS:

1. Emphasize that obesity is the single most important risk factor in Diabetes Mellitus Type 2.
2. Explain how obesity increases the risk for heart disease, infertility, cholelithiasis, musculoskeletal problems, and surgical complications.

OBS-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

OBS-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the process underlying obesity and will be able to relate this process to changes necessary to attain improved health.

STANDARDS:

1. Relate obesity to health outcomes.
2. Emphasize the relationship among obesity, caloric intake, and exercise.
3. Explain that some people have a genetic predisposition to obesity which will require increased persistence to maintain health.

OBS-EX EXERCISE

OUTCOME: The patient will understand the relationship of physical activity in maintaining a healthy body weight, and will strive to increase regular activity by an agreed-upon amount.

STANDARDS:

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

OBS-FU FOLLOW-UP

OUTCOME: The patient will understand that improved health requires a lifelong commitment to lifestyle adaptations which will assist with control of obesity.

STANDARDS:

1. Discuss the individual's responsibility in the management of obesity.
2. Review the patient's plan for lifestyle modification, emphasizing the need for keeping appointments, adhering to dietary modifications and increasing activity levels.
3. Encourage regular weight and blood pressure checks.
4. Reassess exercise and activity levels every 3-6 months.

OBS-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

OBS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the importance of making lifestyle adaptations to attain a healthier body habitus.

STANDARDS:

1. Review dietary modifications and restrictions. Refer to the standards for [OBS-N](#).
2. Emphasize the benefits of regular exercise. **Refer to [WL-EX](#).**
3. Discuss the importance of good hygiene since additional body fat increases perspiration.
4. Discuss the pros and cons of alternate weight loss options, i.e., fad diets, surgery, medications.

OBS-M MEDICATION

OUTCOME: The patient/family will understand that weight loss medications can have side effects or drug interactions and the importance of discussing any over-the-counter or prescription weight loss medications with the health care provider prior to initiating said medication(s).

STANDARDS:

1. Explain the potentially serious adverse effects of the specific interactions of the medication with other drugs (including OTC medications and traditional or herbal medicines).
2. Specifically discuss adverse effects of this medication when combined with specific foods.
3. Emphasize the importance of informing the provider (i.e., physician, pharmacist, nurse) of any drug interaction(s) that have occurred in the past.
4. Discuss the risk/benefit ratio of the medication(s) that are being considered.

OBS-N NUTRITION

OUTCOME: The patient will identify dysfunctional eating patterns and plan adaptations in eating which will promote weight loss and improved health.

STANDARDS:

1. Assess current eating patterns. Identify helpful and harmful components of the patient's diet.
2. Emphasize the importance of regular meal times and of eliminating snack foods, fatty foods, fatty red meats, reducing sodium consumption and adding more fresh fruits, fresh vegetables and fiber to the diet.
3. Emphasize the necessary component — water — in a healthy diet. Reduce the use of colas, coffee, and alcohol.
4. Review which community resources exist to assist with diet modification and weight control. Refer to dietitian as appropriate.
5. Anticipate psychological or social stressors which may lead to over-consumption. Teach the patient to splurge by plan, not by impulse.
6. Teach person(s) responsible for food purchase and preparation techniques for avoiding fats and simple carbohydrates in meal plans.

OBS-P PREVENTION

OUTCOME: The patient/family will understand the importance of attaining and maintaining a healthy body weight throughout the life span.

STANDARDS:

1. Emphasize that obesity often begins at conception. Discuss the roles of maternal obesity, gestational diabetes, and overfeeding of infants.
2. Encourage a physically active lifestyle. **Refer to [WL-EX](#).**
3. **Refer to [WL-N](#) and [OBS-C](#).**
4. Identify cultural, familial, and personal perceptions of body image and their relationship to obesity and health.

OBS-SM STRESS MANAGEMENT

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

STANDARDS:

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

OBS-TE TESTS

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

STANDARDS:

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

ORTH—Orthopedics

ORTH-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of the body part affected.
2. Discuss the changes to the anatomy and physiology as a result of this condition and/or injury as applicable.
3. Discuss the impact of these changes on the patient's health, well-being and/or mobility.

ORTH-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of orthopedic conditions and/or procedures.

STANDARDS:

1. Explain that failure to fully participate in the prescribed therapy may result in a deficit in function of the limb or body part involved.
2. Discuss common and important complications associated with this illness, injury or condition.

ORTH-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the current knowledge regarding the patient's orthopedic condition and symptoms.

STANDARDS:

1. Explain that an orthopedic condition involves the bones and/or joints. Describe the specific condition.
2. Discuss the current information regarding causative factors and pathophysiology of this disease state/condition.
3. Discuss the signs/symptoms and usual progression of this disease state/condition.
4. Discuss the signs/symptoms of exacerbation/worsening of this disease state/condition.

ORTH-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate, when appropriate, the proper use and care of orthopedic equipment.

STANDARDS:

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

ORTH-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize that fully participating in the treatment plan is the responsibility of the patient.
2. Review the treatment plan with the patient/family, emphasizing the need for keeping appointments, fully participating with the medication and physical therapy plan.
3. Review the symptoms which should be reported and measures to take if they occur.
4. Stress the importance of keeping follow-up appointments and continuing the therapy for its prescribed duration.

ORTH-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

ORTH-M MEDICATIONS

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

STANDARDS:

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

ORTH-N NUTRITION

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

STANDARDS:

1. Explain that diet can be a contributing factor in the disease process.
2. Explain that diet alone cannot usually treat orthopedic conditions.
3. Encourage the patient to include foods rich in calcium, such as dairy products.
4. Refer to registered dietician as appropriate.

ORTH-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management and the importance of fully participating in the plan.

STANDARDS:

1. Explain that pain management is specific to the disease process/injury of this particular diagnosis and management may be multifaceted.
2. Explain the role of narcotics and other medications in pain management as appropriate.
3. Explain the use of heat and/or cold in the relief of pain as appropriate.
4. Explain that the use of non-pharmacologic measures (i.e., such as physical therapy, imagery, TENS units) in the control of pain.
5. Discuss the importance of restricting the use of the affected body part as recommended by the provider as a pain management tool.

ORTH-PT PHYSICAL THERAPY

OUTCOME: The patient/family will understand the importance of regular physical therapy and will develop a plan to keep physical therapy appointments and fully participate in the physical therapy plan.

STANDARDS:

1. Review the current information regarding the physical therapy indicated for this condition/injury.
2. Explain the benefits, risks and alternatives to the physical therapy plan.
3. Assist the patient/family with a physical therapy plan indicated for this condition/injury. Explain that this may include visits with the physical therapist as well as home exercises.
4. Emphasize that it is the responsibility of the patient to follow the plan.

ORTH-P PREVENTION

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

STANDARDS:

1. List lifestyle habits that increase the risk for the onset, progression, or spread of the specific orthopedic condition or predispose to injury.
2. Identify behaviors that reduce the risk for the onset, progression, or spread of the specific orthopedic condition or predispose to injury.
3. Assist the patient in developing a plan for prevention of orthopedic conditions and/or injuries.

ORTH-PRO PROCEDURES

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

STANDARDS:

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

ORTH-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

1. Explain that injuries are a major cause of death.
2. Discuss the regular use of seat belts and children's car seats and obeying the speed limit.
3. Explain that the use of alcohol and/or drugs increases the risk of injury or death, especially when used by someone operating a motor vehicle or other equipment.
4. Assist the family in identifying ways to adapt the home to improve safety and prevent injuries, as appropriate.
5. Discuss injury prevention adaptations appropriate to the patient's age, disease state, or condition.
6. Identify which community resources promote safety and injury prevention and refer as appropriate.

ORTH-TE TESTS

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

STANDARDS:

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

ORTH-TX TREATMENTS

OUTCOME: The patient/family will understand the treatment options that may be used to treat the specific condition or injury.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options.
2. Discuss the treatment plan, including lifestyle adaptations, pharmacologic, surgical, and psychosocial aspects of the treatment plan.
3. Discuss the importance of fully participating in the treatment plan, including scheduled follow-up and physical therapy.

ORTH-WC WOUND CARE

OUTCOME: The patient/family will understand the importance of wound care and demonstrate how to perform appropriate wound care as applicable.

STANDARDS:

1. Explain the risks and benefits of appropriate wound care and how it relates to the specific condition.
2. Explain step by step how wound care is to be performed. Observe return demonstration as appropriate.
3. Discuss the importance of aseptic technique and appropriate wound care in preventing infection.
4. As appropriate, discuss the proper disposal of soiled wound care items.

P**PM—Pain Management****PM-AP ANATOMY AND PHYSIOLOGY**

OUTCOME: The patient/family will understand that the perception of pain is highly complex and individualized.

STANDARDS:

1. Explain that pain normally acts as the body's warning signal of tissue injury. This warning signal notifies the body to withdraw from the stimulus.
2. Discuss the difference between the body's physiological response to pain and the person's perception of the event.
3. Explain that tissue damage causes the release of chemicals which result in the sensation of pain. Most pain medications work by blocking these chemicals.
4. Explain that touch type signals (i.e., rubbing, stroking, touching) may block the brain's reception of pain signals.

PM-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

PM-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pain symptoms, type (i.e., chronic, acute, malignant) and the causes of the patient's pain if known.

STANDARDS:

1. Explain that the patient is the primary source of information about the pain's location, quality, intensity, onset, precipitating or aggravating factors and the measures that bring relief.
2. Emphasize the importance of communicating information about the pain to the provider.
3. Discuss that the patient's presentation of symptoms is a unique combination of the type of pain, individual experiences and sociocultural adaptive responses.
4. Explain that pain tolerance varies greatly from person to person and in the same individual under different circumstances.
5. Explain that it is very rare for patients to become addicted to drugs administered for the relief of acute pain.

PM-EQ EQUIPMENT

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

STANDARDS:

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

PM-EX EXERCISE

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

STANDARDS:

1. Explain that moderate exercise may increase energy, improve circulation, enhance sleep, and reduce stress and depression, and relieve some types of pain.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
 - a. 30 minutes 5 days per week
 - b. 15 minutes bouts 2 times a day 5 days per week
 - c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to [WL-EX](#).**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

PM-FU FOLLOW-UP

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

STANDARDS:

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

PM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the patient's specific disease process, pain management issues, support groups or community resources as appropriate.

STANDARDS:

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

PM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle changes necessary to optimize performance of everyday activities and promote healing.

STANDARDS:

1. Explain that treatment of pain is very individualized, i.e., medication, rest, exercise, and disease-specific treatment modalities.
2. Explain that exercise and social involvement (i.e., familial, traditional, cultural) may decrease the subjective sense of pain and the depression and anger often associated with pain.
3. Review lifestyle areas that may require adaptations (i.e., diet, physical activity, sexual activity, bladder/bowel habits, role changes, communication skills and interpersonal relationships). Discuss lifestyle changes in relation to disease progression. Review activity limitation as appropriate.
4. Discuss techniques that may reduce stress and depression such as meditation and biofeedback as appropriate.
5. Refer to community resources as appropriate. **Refer to [WL](#).**

PM-M MEDICATION

OUTCOME: The patient/family will verbally summarize the medication regimen and the importance of full participation with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications.
2. Emphasize that excess sedation and euphoria are not goals of palliative pharmacologic therapy.
3. Explain that chronic pain is usually irreversible and often progressive.
4. Discuss patient/family concerns about addiction. Explain the difference between psychological addiction and physical dependence upon prescribed pain medications. Reinforce that addiction is psychological dependence on a drug; and is not equivalent to tolerance or physical dependence.
5. Explain that insomnia and depression are often significant problems for chronic pain patients. Emphasize the importance of developing a plan with the provider to address these issues as appropriate.
6. Explain that spiritual pain is a reality and cannot be relieved with medications.
7. Discuss the importance of full participation with the medication regimen in order to assure optimal comfort levels. For example, round-the-clock dosing of pain medication is more effective in the treatment of chronic pain than medications that are taken after the pain recurs.
8. Discuss the use of adjunctive medication, if indicated, to control analgesic side effects, i.e., anti-emetics, laxatives, antacids.
9. Refer to [M](#).

PM-N NUTRITION

OUTCOME: The patient/family will understand the importance of a nutritionally balanced diet in the treatment of their pain and specific disease process. They will be able to identify foods and meal plans that will promote the healing process if applicable.

STANDARDS:

1. Assess current nutritional habits and needs.
2. Emphasize the necessary component - WATER - in a healthy diet.
3. Explain that constipation is a common side-effect of opiates. Dietary measures such as increased water, increased fiber, increased fruit juices and decreased intake of milk products may be helpful. Other control measures should be discussed with the provider prior to initiation.
4. Review the patient's prescribed diet, if applicable. Refer to dietitian or other local resources as indicated.

PM-P PREVENTION

OUTCOME: The patient and/or family will understand the source of pain in relation to the appropriate disease process. They will make a plan to avoid the precipitating factors, minimize disease progression, promote healing; and/or maximize coping strategies.

STANDARDS:

1. Discuss importance of fully participating in treatment plan for an acute injury to reduce the risk of residual chronic pain.
2. Discuss good body mechanics in order to reduce risk of musculoskeletal injuries.

PM-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand that grief reactions are common with chronic pain and that depression may be seen and that treatments are available for these problems.

STANDARDS:

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

PM-TE TESTS

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

STANDARDS:

1. Explain the test ordered, i.e., EMG, CT scan, ultrasound.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
3. Discuss any necessary preparation for the test(s).

PM-TX TREATMENT

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

STANDARDS:

1. Discuss with the patient/family the possible appropriate noninvasive pain relief measures, i.e., TENS units, heat, cold, massage.
2. Discuss with the patient/family the possible alternative pain relief measures, when appropriate, i.e., meditation, imagery, acupuncture, healing touch, traditional healer, hypnosis.
3. Discuss with the patient/family the possible appropriate pharmacologic pain relief measures. **Refer to [PM-M](#).**
4. Discuss with the patient/family the possible appropriate procedural or operative pain management techniques, i.e., nerve block, intrathecal narcotics, local anesthesia.
5. Emphasize the importance of the patient/family's active involvement in the development of a treatment plan.

PC—Pancreatitis

PC-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

PC-DP DISEASE PROCESS

OUTCOME: The patient will understand the causes and symptoms of pancreatitis.

STANDARDS:

1. Explain that pancreatitis is an inflammation of the pancreas caused by activation of digestion enzymes produced by the pancreas.
2. Review the signs of pancreatitis, i.e., steady, boring pain radiating to the back or shoulder; low-grade fever; bulky, pale, foul-smelling stools; nausea and/or vomiting; abdominal distention, jaundice.
3. Relate some common causes, i.e., alcohol ingestion, biliary tract disease, postoperative, post-trauma, metabolic conditions, infections, drug-associated, connective tissue disorders with vasculitis.

PC-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of fully participating in treatment regimen and make a plan for appropriate follow-up.

STANDARDS:

1. Discuss the individual's responsibility in the management of pancreatitis.
2. Review the treatment plan with the patient, emphasizing the need for keeping appointments and adhering to dietary modifications.
3. Emphasize the importance of regular medical follow-up and keeping clinic appointments.
4. Encourage participation in a self-help group, such as AA, if appropriate.

PC-L LITERATURE

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

STANDARDS:

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

PC-M MEDICATIONS

OUTCOME: The patient will understand the type of medication being prescribed, dosage and administration of the medication. They will also be aware of the proper storage of the medication and possible side effects of the drugs.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication.
2. Emphasize the importance of maintaining full participation in the medication regimen and monitoring schedule.
3. Instruct patient on proper administration of the drug.

PC-N NUTRITION

OUTCOME: The patient will understand ways to minimize future episodes of pancreatitis through nutritional modifications.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between alcohol and pancreatitis.
3. Emphasize the importance of total abstinence from alcohol.
4. Encourage the patient to eat frequent, small meals that are bland and low fat.
5. Encourage the patient to avoid coffee.
6. Assist the patient to develop an appropriate diet plan.
7. Instruct that in many cases a regular diet may be very gradually resumed.
8. Refer to registered dietician as appropriate.

PC-P PREVENTION

OUTCOME: The patient will be able to identify factors related to pancreatitis and, if appropriate, have a plan to prevent future episodes.

STANDARDS:

1. Explain that the major cause of pancreatitis in the US is alcohol ingestion.
2. Explain that if alcohol ingestion was a factor, that complete abstinence from alcohol will decrease the chance of future pancreatitis.
3. Explain that, in some cases, dietary changes may prevent attacks or reduce their severity.

PC-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that pain management in gallbladder disease is specific to the disease process of this particular patient and may be multifaceted.
2. Explain that often antispasmodics may be helpful.
3. Explain that short term use of narcotics may be helpful in pain management.
4. Explain that other medications may be helpful to control the symptoms of nausea and vomiting.
5. Explain that administration of fluids may help with pain relief and resolution of symptoms.
6. Refer to [PM](#).

PC-TE TESTS

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

STANDARDS:

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

PC-TX TREATMENT

OUTCOME: The patient will understand the treatment plan.

STANDARDS:

1. Explain that pancreatic secretions can be minimized by eliminating oral ingestion of food and fluid. This must be done to “rest” the pancreas.
2. Explain the proper use of pain medications. Refer to [PM](#).
3. Explain that, if the pancreatitis episode is prolonged, total parenteral nutrition may be required to maintain nutrition and promote healing.
4. Refer to community resources as appropriate.

PDM—Prediabetes

PDM-C COMPLICATIONS

OUTCOME: The patient/family/caregiver will understand common or serious complications of abnormal fasting blood glucose level.

STANDARDS:

1. Explain that fasting blood glucose levels above 100 mg/dL but less than 126 mg/dL and 2 hour post prandial between 140-200 mg/dL are diagnostic of prediabetes and that prediabetes may progress to Type 2 Diabetes.
2. Emphasize that optimal control of blood sugar can reverse or prevent progression of PDM.
3. Emphasize that optimal control of blood sugar can reduce the risk of complications.
4. State that PDM is a disease that needs to be monitored for progression and complications. Routine examinations are essential.
5. Discuss higher risk factors of PDM, i.e., heart attack, stroke. **Refer to [CVA](#), [CAD](#), [DM](#) and [PVD](#).**
6. Discuss complications that can occur if PDM develops into Diabetes, i.e., heart disease, stroke, eye problems, kidney damage.

PDM-DP DISEASE PROCESS

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

STANDARDS:

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

PDM-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in reducing insulin resistance and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

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

PDM-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of early intervention to prevent the progression of PDM to Type 2 Diabetes.
2. Discuss the procedure for making appointments.
3. Discuss any necessary preparation for lab test(s). **Refer to [PDM-TE](#).**

PDM-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

PDM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family/caregiver will understand the lifestyle adaptations necessary to prevent or delay the progression of PDM and develop a realistic plan to accomplish this.

STANDARDS:

1. Emphasize that nutrition and exercise are the critical components in improving impaired glucose tolerance.
2. Emphasize that the complications (i.e., heart attack, stroke) result from the higher than normal blood sugar levels and that the goal of management is to keep blood sugar as near to normal as possible.

PDM-N NUTRITION

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

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation and intake.
2. Review the food pyramid and its role in meal planning. Refer to registered dietician or to other local resources as appropriate.
3. Emphasize the importance of reading food labels. Instruct the patient/family as necessary.
4. Discuss the merits of various food preparation methods, i.e., broiling or baking is preferred over frying, avoid gravies and sauces, rinsing or blotting excess grease.
5. Emphasize the importance of portion control (appropriate serving sizes).
6. Emphasize that extra caution or planning is required when eating out, using USDA commodities, or going to special events since these foods are usually high in fat and sugar and serving sizes are often inappropriately large.
7. Emphasize that carbohydrates (such as whole grains) and low-fat proteins are preferred and that sugars and fats should be limited.
8. Emphasize the importance of family involvement and early intervention.

PDM-P PREVENTION

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

STANDARDS:

1. Discuss the risk factors for PDM and Type 2 DM, i.e., obesity, sedentary lifestyle.
2. Explain that following an appropriate meal plan and increasing activity levels will reduce the risk of progression of PDM to Type 2 Diabetes.
3. Emphasize the importance of regular screening. Discuss current recommendations for screening.

PDM-TE TESTS

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

STANDARDS:

1. Explain the test(s) ordered, i.e., FBS, HgbA_{1C}, Fasting Lipid Profile.
2. Explain any necessary preparation prior to the test(s).
3. Explain the indications, risks and benefits of the test(s).
4. Explain the meaning of test results in relation to what “normal” results are.
5. Explain the test as it relates to planning the course of treatment.

R**XRAY—Radiology/Nuclear Medicine****XRAY-C COMPLICATIONS**

OUTCOME: The patient/family will understand the common and important complications that may result from this procedure.

STANDARDS

1. Explain that some patients may have adverse reactions to contrast media or other medications used during radiographic/nuclear medicine procedures.
2. Discuss common and important complications as they apply to the procedure to be performed.
3. Discuss the procedure that will be undertaken if adverse events occur.

XRAY-FU FOLLOW-UP

OUTCOME: The patient/family will understand the conditions that would require follow-up and how to obtain follow-up.

STANDARDS:

1. Discuss the findings that will signify a serious complication or condition.
2. Discuss the procedure for obtaining follow-up appointments.

XRAY-L LITERATURE

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

STANDARDS:

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

XRAY-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of medication therapy as it relates to the procedure to be performed.

STANDARDS:

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

XRAY-PRO PROCEDURE

OUTCOME: The patient/family will understand the radiographic/nuclear medicine procedure to be performed.

STANDARDS:

1. Discuss the method of the radiographic/nuclear medicine procedure that has been ordered.
2. Discuss the indications, risks, and benefits for the proposed procedure.
3. Explain the process and what to expect after the procedure.
4. Explain the necessary preparation, i.e., bowel prep, diet instructions, bathing.
5. Discuss pain management as appropriate.
6. Emphasize post-procedure management and follow-up.

XRAY-S SAFETY

OUTCOME: Explain the procedure used to protect the patient and staff.

STANDARDS:

1. Discuss the use of personal protective equipment (i.e., lead shields, gloves) and their role in preventing transmission of disease or unnecessary radiation exposure.
2. Demonstrate the proper use of equipment to be used.
3. Discuss as appropriate that needles and other infusion equipment are single patient use and will be discarded.
4. Discuss the procedure for accidental needle-stick of the patient or the staff as appropriate.

XRAY-TE TESTS

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

STANDARDS:

1. Explain the test that has been ordered.
2. Explain the necessity, benefits, and risks of the test to be performed. Refer to the primary provider as necessary.
3. Explain any necessary preparation for the test, i.e., fasting.
4. Explain the procedure for obtaining test results.

S**SWI—Skin and Wound Infections****SWI-C COMPLICATIONS**

OUTCOME: The patient/family will understand the complications associated with skin and wound infections.

STANDARDS:

1. Review with the patient/family the symptoms of a generalized infection, i.e., high fever spreading redness, red streaking, increased tenderness, changes in mental status, decreased urine output.
2. Review with the patient/family the effects of uncontrolled skin or wound infections (i.e., cellulitis) or generalized infection, i.e., loss of limb, need for 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, as appropriate, that the use of immunosuppressive or corticosteroid medication may increase the risk for skin and wound infections.
6. Explain, as appropriate, that elevated blood sugar increases the risk of serious skin and wound infections and impedes healing.
7. Review, as appropriate, peripheral vascular disease and/or ischemic ulcers as appropriate. **Refer to [PVD](#).**
8. Discuss with the patient/family the pathophysiologic process of an inflammatory response.

SWI-EQ EQUIPMENT

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

STANDARDS:

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

SWI-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that follow-up appointments should be kept.
4. Explain signs or symptoms that would prompt immediate follow-up, i.e., redness, purulent discharge, fever, increased swelling or pain.

SWI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about skin and wound infections.

STANDARDS:

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

SWI-M MEDICATION

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

STANDARDS:

1. Discuss reason for specific medication in treatment of this patient's infection.
2. Review directions for use and duration of therapy.
3. Discuss expected benefits of therapy as well as the important and common side effects. Discuss side effects that should prompt a return visit.
4. Discuss importance of full participation with medication regimen and how completion of an antibiotic course will help prevent the development of antibiotic resistance.
5. Emphasize the importance of follow-up.

SWI-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to [PM](#).**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Discuss non-pharmacologic measures that may be helpful with pain control.

SWI-P PREVENTION

OUTCOME: The patient/family will understand the appropriate measures to prevent skin and wound infections.

STANDARDS:

1. Discuss avoidance of skin damage by wearing appropriate protective equipment (i.e., proper footwear, long sleeves, long pants, gloves), as appropriate.
2. Explain importance of good general hygiene and cleaning any breaks in the skin and observing for infections. **Refer to [WL-HY](#).**
3. Review importance of maintaining good general health and controlling chronic medical conditions, especially glycemic control in diabetes. **Refer to [DM-FTC](#).**

SWI-TE TESTS

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

STANDARDS:

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

SWI-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, i.e., decreased infection rate, improved healing.
2. Explain the correct procedure for caring for this patient's wound.
3. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained
4. Emphasize the proper methods for disposal of used supplies.
5. Emphasize the importance of follow-up.
6. Discuss any special recommendations or instructions particular to the patient's wound.

SPE—Surgical Procedures and Endoscopy

SPE-C COMPLICATIONS

OUTCOME: The patient/family will understand 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-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

SPE-EQ EQUIPMENT

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

STANDARDS:

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

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-IS INCENTIVE SPIROMETRY

OUTCOME: The patient will understand the reason for use of the incentive spirometer and demonstrate appropriate use.

STANDARDS:

1. Explain that regular and appropriate use of the incentive spirometer according to instructions reduces the risk of respiratory complications including pneumonia.
2. Explain that the optimal body position for incentive spirometry is semi-Fowler's position which allows for free movement of the diaphragm.
3. Instruct the patient to exhale normally and evenly inhale maximally through the spirometer mouthpiece.
4. Encourage the patient to hold the maximal inspiration for a minimum of three seconds to allow for redistribution of gas and opening of atelectatic areas.
5. Instruct the patient to exhale slowly and breathe normally between maneuvers.
6. Instruct the patient to repeat this maneuver as frequently as prescribed.

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 understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to [PM](#).**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Discuss non-pharmacologic measures that may be helpful with pain control.

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 full participation 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, i.e., bathing, bowel preps, diet instructions.
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-TCB TURN, COUGH, DEEP BREATH

OUTCOME: The patient/family will understand why it is important to turn, cough and deep breath and the patient will be able to demonstrate appropriate deep breathing and coughing.

STANDARDS:

1. Explain that it is important to frequently (every 1 to 2 hours) turn, cough and breath deeply to prevent complications such as pneumonia after a surgical procedure. Explain that turning prevents stasis of secretions and breathing deeply and coughing helps to mobilize and clear secretions and keep small airways open.
2. Describe appropriate deep breathing and coughing (take a large breath and hold it for 3 – 5 seconds, exhale and cough shortly 2 to 3 times).
3. Demonstrate appropriate splinting techniques (e.g., using a pillow held tightly to the abdomen over the surgical site).
4. Have the patient return a demonstration of appropriate deep breathing, coughing, and splinting.

SPE-TE TESTS

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

STANDARDS:

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

SPE-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, i.e., decreased infection rate, improved healing.
2. Explain the correct procedure for caring for this patient's wound.
3. Explain signs or symptoms that should prompt immediate follow-up, i.e., increasing redness, purulent discharge, fever, increased swelling/pain.
4. Detail the supplies necessary for the care of this wound (if any) and how/where they might be obtained.
5. Emphasize the importance of follow-up.

T**TO—Tobacco Use**

It is important to screen tobacco use and to record the responses appropriately in the Health Factors. Listed below are the definitions for tobacco use:

- Non-Tobacco Use – *Never* used *any* tobacco products
- Current Smoker – Smokes. Ask number of cigarettes/packs smoked per day
- Current Smokeless – Uses smokeless. Ask number of Cans/plugs per day
- Cessation Smoker – Former smoker, now quit. Document Quit Date _____
- Cessation Smokeless – Former smokeless user, now quit. Document Quit date _____
- Previous Smoker – Smoker who smoked for ____years. Now Quit.
- Previous Smokeless – Smokeless user for ____ years. Now Quit.
- Non-Smoker but smoker in home, i.e., exposed to second hand smoke
- Environmental Exposure – Works in environment (casino, Bingo) with exposure to smoke.
- Ceremonial/Traditional use of tobacco

TO-C COMPLICATIONS

OUTCOME: The patient/family will understand how to avoid the slow progression of disease and disability resulting from tobacco use.

STANDARDS:

1. Discuss the common problems associated with tobacco use and the long term effects of continued use of tobacco, i.e., COPD, cardiovascular disease, numerous kinds of cancers including lung cancer.
2. Review the effects of tobacco use on all family members- financial burden, second-hand smoke, asthma, greater risk of fire, early death of a bread-winner.
3. Discuss the possible implications of tobacco use on newborns, infants and children, as well as being a possible link to SIDS.

TO-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

TO-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the slow progression of disease and disability associated with tobacco use.

STANDARDS:

1. Review the current factual information regarding tobacco use. Explain that tobacco use in any form is dangerous.
2. Explain nicotine addiction.
3. Explain dependency and co-dependency.

TO-EX EXERCISE

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

STANDARDS:

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

TO-FU FOLLOW-UP

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

STANDARDS:

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

TO-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about tobacco use or cessation of use.

STANDARDS:

1. Provide the patient/family with written patient information literature on tobacco use or cessation of use.
2. Discuss the content of the patient information literature with the patient/family.

TO-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will see tobacco abstinence as a way of life.

STANDARDS:

1. Discuss the patient's use/abuse of tobacco.
2. Discuss tips for stress relief and healthy "replacement habits".
3. Discuss the difference between recreational use of tobacco versus traditional or ceremonial use of tobacco.

TO-M MEDICATIONS

OUTCOME: If applicable, the patient/family will understand the importance of fully participating with a prescribed medication regimen.

STANDARDS:

1. Review the proper use, benefits and common side effects of the prescribed medication.
2. Briefly review the mechanism of action of the medication if appropriate.
3. Explain that medications can help only if the patient is ready to quit and that medications work best in conjunction with counseling and lifestyle-modification education.
4. Explain that some medications may not work right away but will require a few days to a few weeks to take effect.
5. Emphasize that there may be dangers in using medications in conjunction with smoking and that some medications may be addictive, so it is important to have a dose-tapering regimen and keep to it.

TO-QT QUIT

OUTCOME: The patient/family will understand that smoking is a serious threat to their health, that they have been advised by health professionals to quit, and how participation in a support program may prevent relapse.

STANDARDS:

1. Discuss the importance of quitting tobacco use now and completely.
2. Establish a quit date and plan of care.
3. Review the treatment and support options available to the patient/family.
4. Review the value of close F/U and support during the first months of cessation.

TO-RTC READINESS TO CHANGE

OUTCOME: The patient/family will understand

STANDARDS

RTC 1 The patient has no interest in making the recommended change.
Precontemplation (Ready in more than 6mos)

RTC 2 The patient has begun to show interest in making the recommended change. Contemplation (Ready in 1-6 mo)

RTC 3 The patient is beginning to make preparations to make the change.
Preparation (Ready in 30 days or less)

RTC 4 The patient is actively making a change. Action (Quitting 0-6mo)

RTC 5 The patient has continued to Maintenance (quit for at least 6 months or more)

TO-SCR SCREENING

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

STANDARDS

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

TO-SHS SECOND-HAND SMOKE

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

STANDARDS:

1. Define “passive smoking”, ways in which exposure occurs:
 - a. smoldering cigarette, cigar, or pipe
 - b. smoke that is exhaled from active smoker
 - c. smoke residue on clothing, upholstery, carpets or walls.
2. Discuss harmful substances in smoke
 - a. nicotine
 - b. benzene
 - c. carbon monoxide
 - d. many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness in people who are exposed to cigarette smoke either directly or via second-hand smoke. Explain that this risk is even higher for people with pulmonary diseases like COPD or asthma.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Discuss not smoking around infants and children, including in the home and in the car. Second hand smoke increases the risk of SIDS. Encourage smoking cessation.

TO-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in tobacco abuse and its effect on tobacco cessation.

STANDARDS:

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

U**UC—Ulcerative Colitis****UC-C COMPLICATIONS**

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

STANDARDS:

1. Explain that some possible complications of ulcerative colitis are colon perforation, hemorrhage, toxic megacolon, abscess formation, stricture, anal fistula, malnutrition,, anemia, electrolyte imbalance, skin ulceration, arthritis, ankylosing spondylitis, and cancer of the colon.
2. Explain that complications may be delayed, minimized or prevented with prompt treatment of exacerbation.
3. Discuss the symptoms of exacerbation that trigger the need to seek medical attention, i.e., unusual abdominal pain, blood in stools, fever, weight loss, change in frequency of stools, joint pain.

UC-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

UC-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of their specific bowel disease.

STANDARDS:

1. Explain that ulcerative colitis is an inflammatory disease of the mucosa and, less frequently, the submucosa of the colon and rectum.
2. Explain that the exact cause of ulcerative colitis is unknown, but may be related to infection, stress, allergy, autoimmunity and familial predisposition.
3. Explain that this disease is most common during young-adulthood to middle life.
4. Explain that the symptoms are diarrhea, abdominal cramping, weight loss, anorexia, nausea, vomiting and abdominal pain.
5. Explain that ulcerative colitis is characterized by remissions and exacerbations.
6. Explain that careful medical management may eliminate/postpone the need for surgical intervention.

UC-FU FOLLOW-UP

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

STANDARDS:

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

UC-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

UC-M MEDICATIONS

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

STANDARDS:

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

UC-N NUTRITION

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

STANDARDS:

1. Assess current nutritional habits.
2. Advise the patient to avoid dairy products if the patient is lactose intolerant.
3. Encourage the patient/family to maintain a well-balanced, low-residue, high-protein diet.
4. Assist the patient/family to identify foods which cause irritation and encourage them to eliminate or minimize these in the diet.
5. Advise the patient to avoid cold or carbonated foods or drinks which increase intestinal motility.
6. Assist the patient/family in developing appropriate meal plans. Encourage frequent, small meals and chew food thoroughly.
7. Explain that supplementation with vitamins and minerals may be necessary.
8. Refer to dietitian as appropriate.

UC-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of colon disease.

STANDARDS:

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

UC-PM PAIN MANAGEMENT

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

STANDARDS:

1. Discuss the plan for sedatives and tranquilizers to provide, not only for rest, but to decrease peristalsis and subsequent cramping.
2. Instruct the patient in careful cleansing and protection of the perianal skin to provide comfort and prevent painful excoriation.
3. Explain that short term use of narcotics may be helpful in acute pain management.
4. Advise the patient not to use over the counter pain medications without checking with his/her provider.

UC-SM STRESS MANAGEMENT

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

STANDARDS:

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

UC-TE TESTS

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

STANDARDS:

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

UC-TX TREATMENT

OUTCOME: The patient/family will understand the appropriate treatment for ulcerative colitis and have a plan to fully participate in the treatment regimen. The patient/family will further understand the risk/benefit ratio of the testing proposed as well as alternatives to testing and the risk of non-testing.

STANDARDS:

1. Discuss the specific treatment plan, which may include the following:
 - a. Bedrest
 - b. IV fluid replacement to correct dehydration
 - c. Clear liquid diet, or in severe cases, parenteral hyperalimentation to rest the intestinal tract and restore nitrogen balance
 - d. Sulfasalazine, for its antibacterial and anti-inflammatory effects
 - e. Corticosteroids, systemically or by rectal instillation, to decrease inflammation
 - f. Colectomy.
2. Discuss the risk/benefit ratio and alternatives to treatment as well as the risk of non-treatment.