INDIAN HEALTH SERVICE

Patient and Family Education Protocols and Codes (PEPC)

PEDIATRIC CODES

11th Edition
January 2005

FOREWORD

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

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

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

Michale Ratzlaff, M.D. or Kelton H. Oliver, M.D.
PEP-C
Alaska Native Medical Center
4315 Diplomacy Drive
Anchorage, Alaska 99508
mdratzlaff@southcentralfoundation.org

kholiver@southcentralfoundation.org

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

FOREWORD TO THE 11TH EDITION OF THE PATIENT EDUCATION PROTOCOLS

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

Committee Co-Chair
CDR Kelton Oliver, MD
Family Practice
Alaska Native Medical Center (AK)
kholiver@southcentralfoundation.org

Committee Co-Chair
CDR Michale Ratzlaff, MD
Pediatrician
Alaska Native Medical Center (AK)
mdratzlaff@southcentralfoundation.org

Cecilia Butler, RD, MS, CDE
Dietician
Santa Fe Indian Hospital (NM)
cbutler@abq.ihs.gov

CAPT Susan Dethman, MS, RD, CDE, CHES
Public Health Nutritionist
Wewoka IHS Clinic (OK)
Susan.Dethman@ihs.gov

Dar Buena-Suerte Goodman, RN
Ambulatory Care Nurse Manager
Yakama Indian Health Center (WA)
dbuena@yak.portland.ihs.gov

LCDR Christopher C. Lamer, Pharm.D., BCPS, NCPS, CDE
Pharmacist
Cherokee Service Unit (NC)
Chris.lamer@ihs.gov

LCDR Sharon L. John, RN, BSN, BA.
Clinical Nurse Specialist
Warm Springs Health and Wellness Center (OR)
sjohn@wsp.portland.ihs.gov

Linda Lucke, R.N., B.S.N.
Quality Management Coordinator
Blackfeet Service Unit (MT)
Linda.lucke@mail.ihs.gov

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

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

Sonya Vann, R.N., B.S.N., B.A.
ICU Unit Manager
WW Hastings Hospital (OK)
Sonya.vann@mail.ihs.gov

Mary Wachacha, Chief
IHS Health Education Program
Rockville, MD
mwachach@hqe.ihs.gov

TABLE OF CONTENTS

Use and Documentation of Patient Education Codes

Why Use the Codes?

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

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

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

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

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

SOAP Charting and the Codes

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

How to Use the Codes

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

The educator should document the education using the following steps:

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

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

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

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

Recording the Patient's Response to Education

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

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

Documenting Patient Education (Forms)

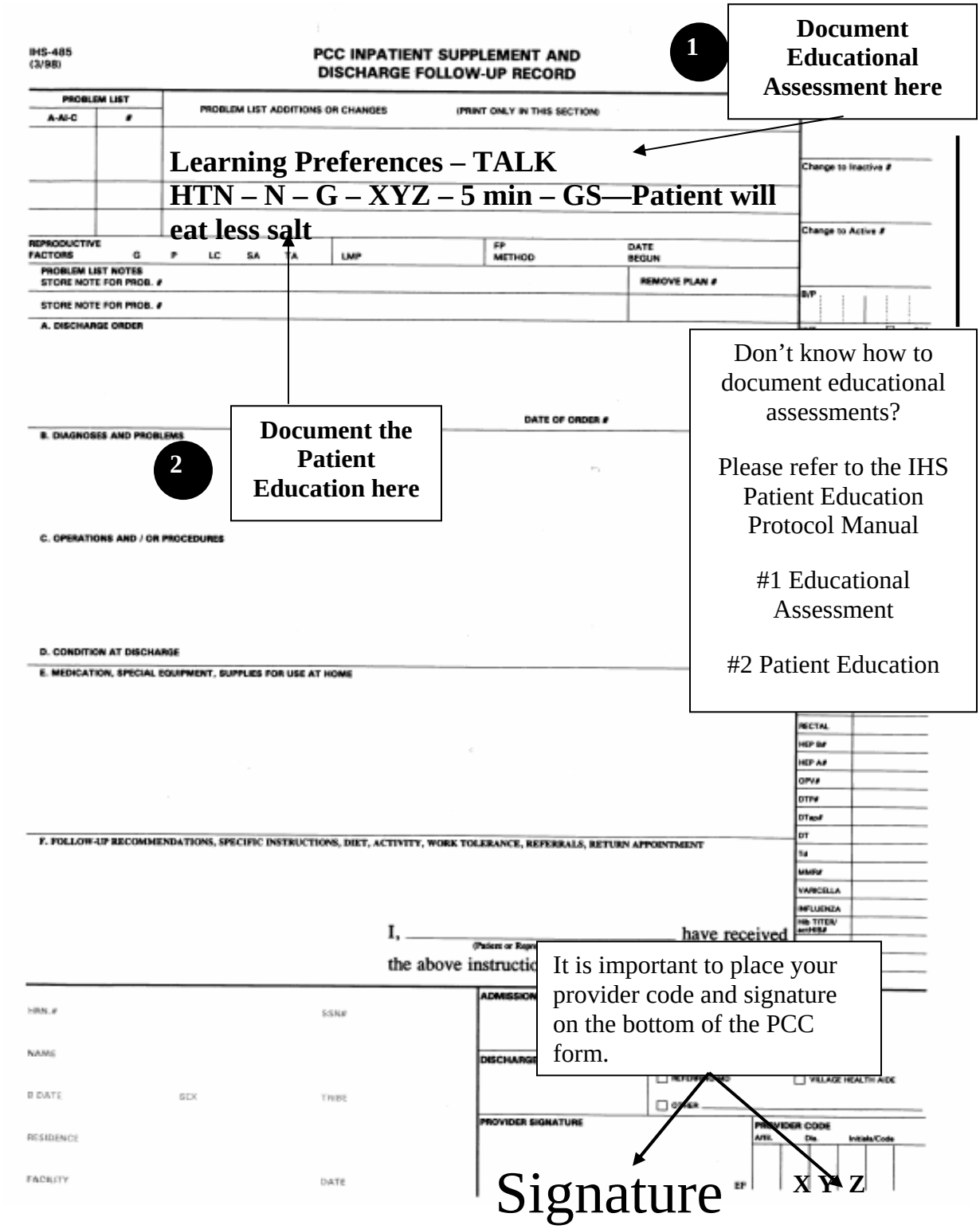


Figure 1: ***Documenting Patient Education on the PCC Inpatient Supplement and Discharge Follow-Up Record form.***

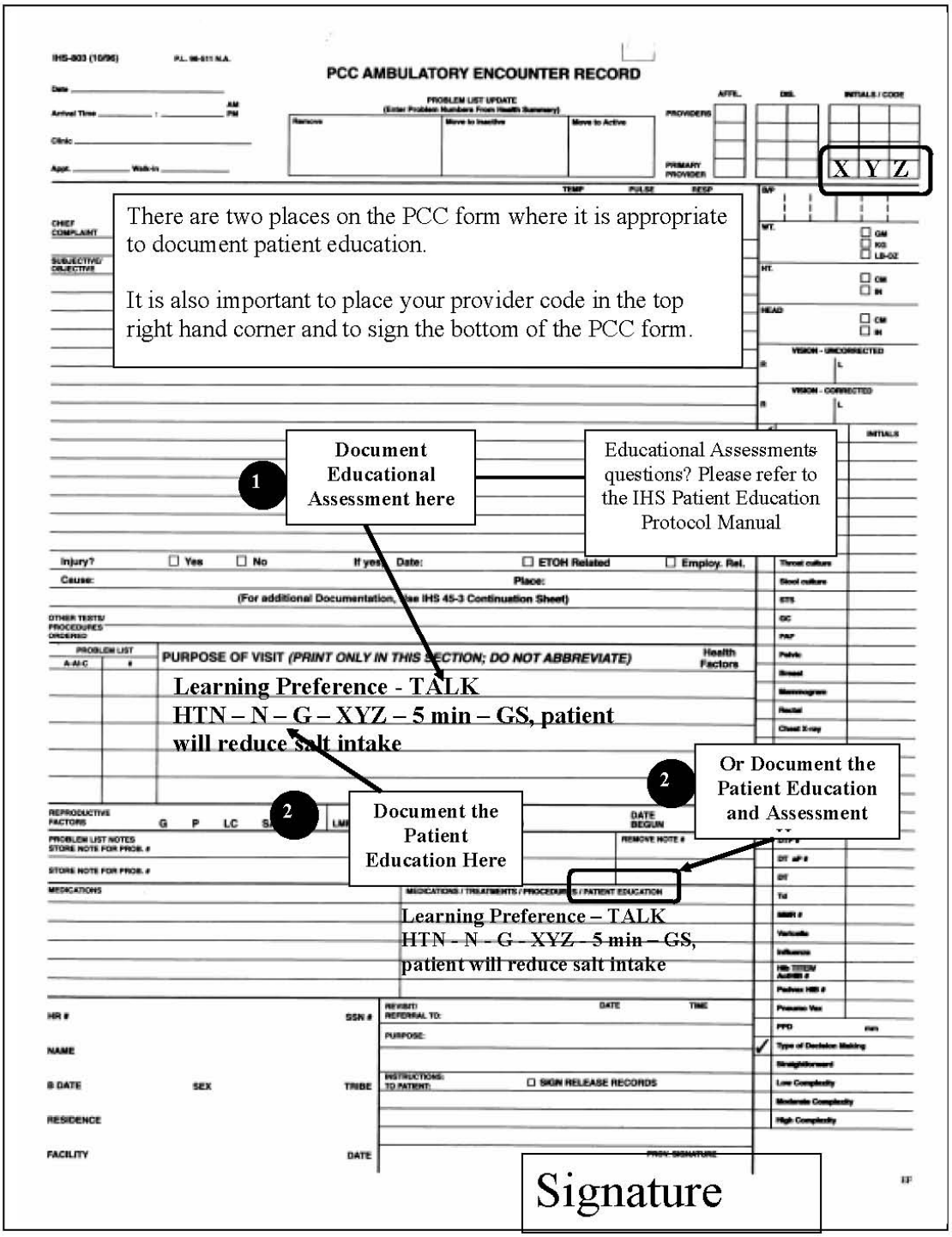


Figure 2: Documenting Patient Education with the PCC Ambulatory Encounter Record form

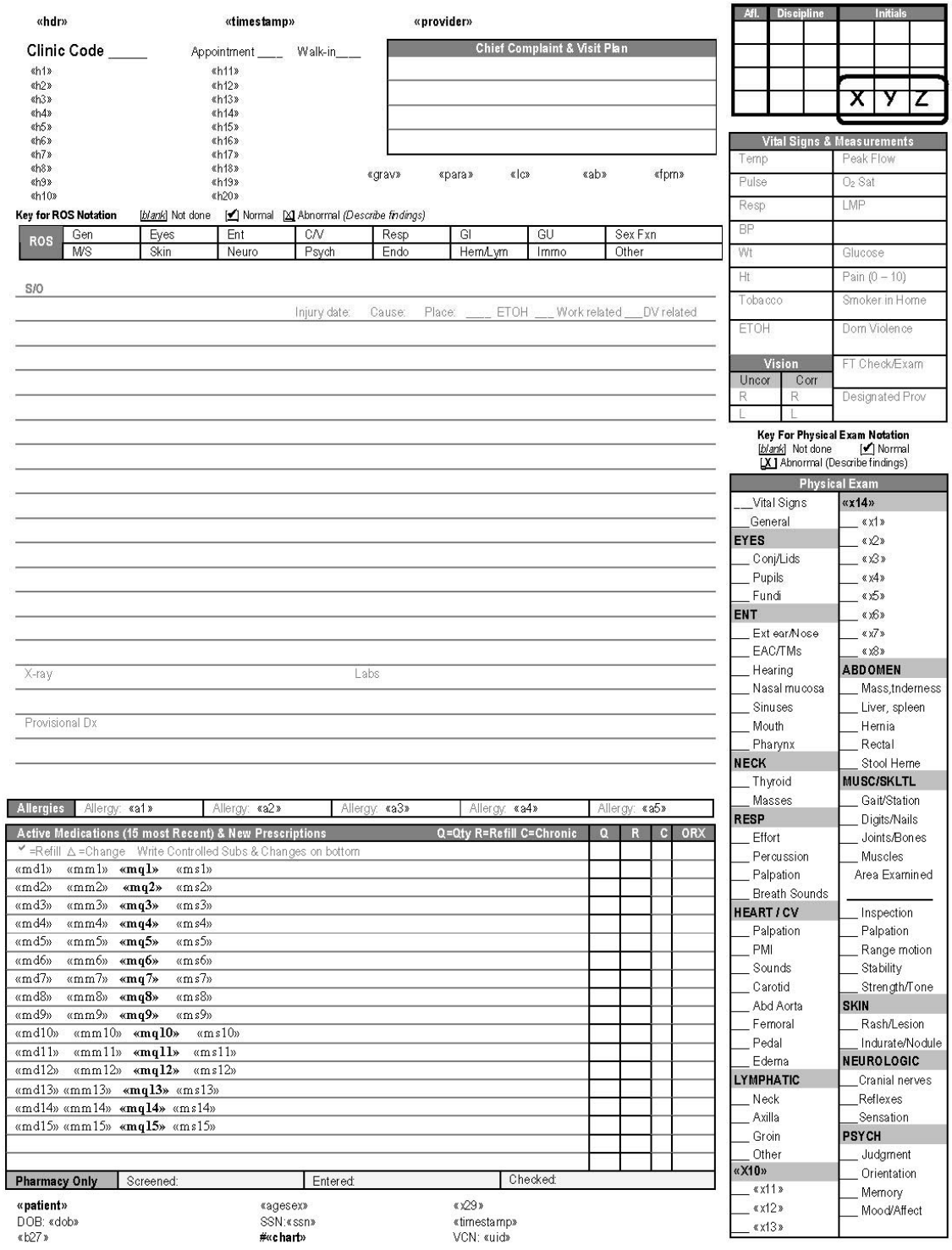


Figure 3: Documenting Patient Education on a PCC+ form, page 1

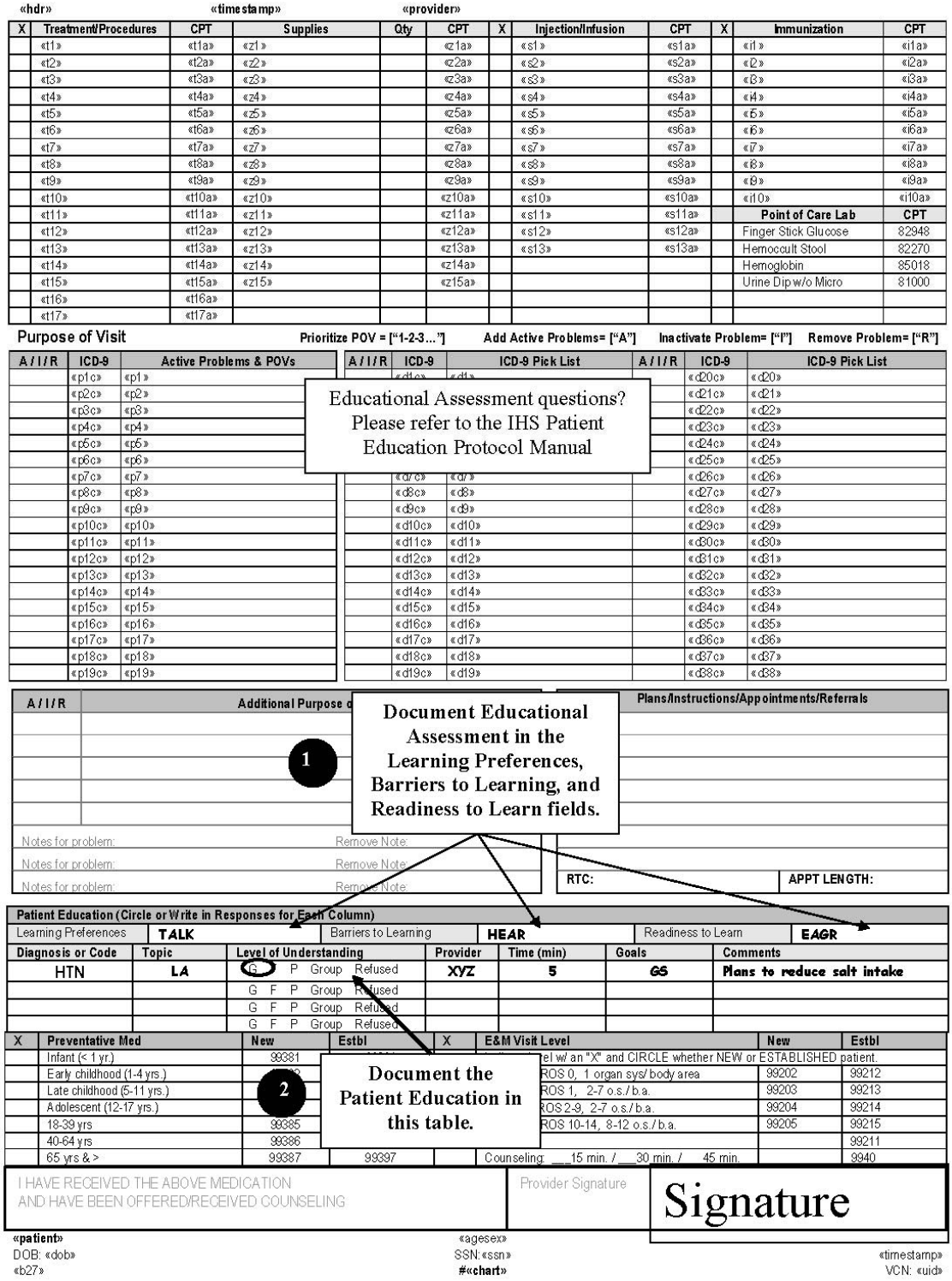
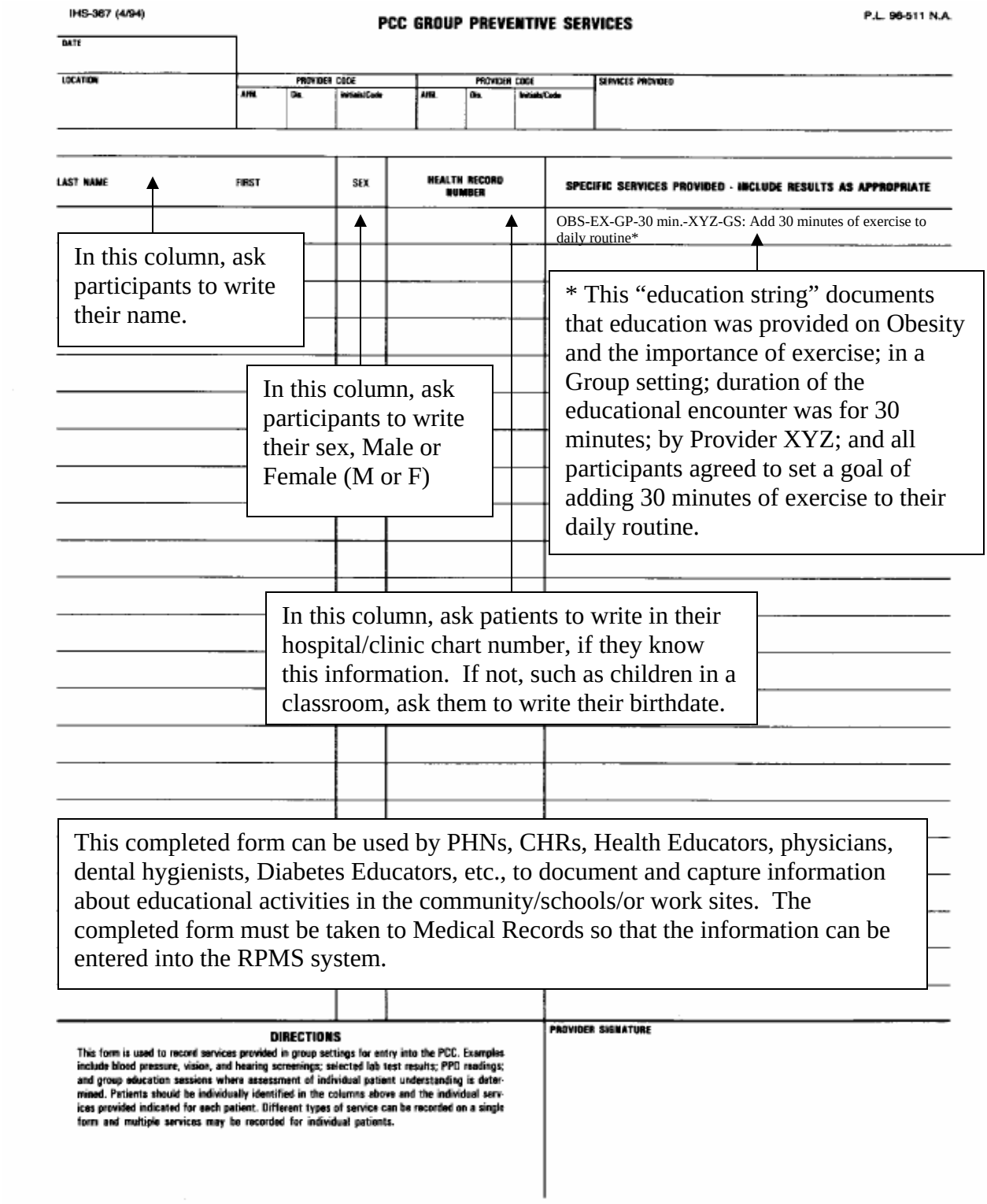


Figure 4: Documenting Patient Education on a PCC+ form, page 2

USE AND DOCUMENTATION OF PATIENT EDUCATION CODES

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



IHS-367 (4/94)

PCC GROUP PREVENTIVE SERVICES

P.L. 86-511 N.A.

DATE

LOCATION

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

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

SERVICES PROVIDED

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

In this column, ask participants to write their name.

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

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

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

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

DIRECTIONS

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

PROVIDER SIGNATURE

USE AND DOCUMENTATION OF PATIENT EDUCATION CODES

READINESS TO LEARN
(RL Code)

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

Assessed each teaching session

PATIENT'S RESPONSE TO EDUCATION (Level of UNDERSTANDING)

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

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

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

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

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

List measures taken to address above barriers:

Comments: ____

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

Patient Identification

Providers please sign on back of form

Signature:	Initials/Provider code:	

Reimbursement for Patient Education

Preventive Medicine Services

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

Reimbursement for Patient Education

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

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

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

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

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

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

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

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

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

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

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

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

Documentation Requirements:

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

Coordination of Care

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

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

Important Aspects concerning Reimbursement for PATIENT EDUCATION

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

Documentation of Evaluation and Management (E/M) Services

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

BRIEF Sample - Office Visits, Established Patients

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

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

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

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

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

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

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

General Education Codes

Guidelines For Use

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

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

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

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

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

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

For example:

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

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

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

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

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

General Education Topics

AP - ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

C - COMPLICATIONS

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

STANDARDS:

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

DP - DISEASE PROCESS

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

STANDARDS:

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

EQ - EQUIPMENT

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

STANDARDS:

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

EX - EXERCISE

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

STANDARDS:

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

FU - FOLLOW-UP

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

STANDARDS:

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

HM - HOME MANAGEMENT

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

STANDARDS:

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

HY - HYGIENE

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

STANDARDS:

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

L - PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

LA - LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

M - MEDICATIONS

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

STANDARDS:

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

N - NUTRITION

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

STANDARDS:

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

P - PREVENTION

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

STANDARDS:

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

PRO - PROCEDURES

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

STANDARDS:

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

S - SAFETY

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

STANDARDS:

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

TE - TESTS

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

STANDARDS:

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

TX - TREATMENT

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

STANDARDS:

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

MNT—Medical Nutrition Therapy

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

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

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

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

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

EDUCATION NEEDS ASSESSMENT CODES

INDIAN HEALTH SERVICE
EDUCATION NEEDS ASSESSMENT CODES

BAR—Barriers to Learning

BAR-BLND BLIND

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

STANDARDS:

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

BAR-COGI COGNITIVE IMPAIRMENT

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

STANDARDS:

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

BAR-DEAF DEAF

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

STANDARDS:

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

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

BAR-DNRE DOESN'T READ

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

STANDARDS:

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

BAR-EMOI EMOTIONAL IMPAIRMENT

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

STANDARDS:

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

BAR-FIMS FINE MOTOR SKILLS DEFICIT

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

STANDARDS:

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

BAR-HEAR HARD OF HEARING

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

STANDARDS:

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

BAR-INTN INTERPRETER NEEDED

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

STANDARDS:

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

BAR – NONE NO BARRIERS

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

STANDARDS:

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

BAR-STRS SOCIAL STRESSORS

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

STANDARDS:

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

BAR-VALU VALUES/BELIEF

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

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

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

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

STANDARDS:

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

BAR-VISI VISUALLY IMPAIRED

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

STANDARDS:

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

LP—Learning Preference

LP-DOIT DO/PRACTICE

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

STANDARDS:

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

LP-GP SMALL GROUP

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

STANDARDS:

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

LP-READ READ

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

STANDARDS:

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

LP-TALK TALK

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

STANDARDS:

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

LP-VIDO VIDEO

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

STANDARDS:

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

RL—Readiness to Learn

RL-DSTR DISTRACTION

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

STANDARDS:

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

RL – EAGR EAGER TO LEARN

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

STANDARDS:

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

RL – RCPT RECEPTIVE

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

STANDARDS:

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

RL-PAIN PAIN

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

STANDARDS:

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

RL-SVIL SEVERITY OF ILLNESS

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

STANDARDS:

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

RL-UNRC UNRECEPTIVE

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

STANDARDS:

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

A

ABD—Abdominal Pain

ABD-C COMPLICATIONS

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

STANDARDS:

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

ABD-DP DISEASE PROCESS

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

STANDARDS:

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

ABD-FU FOLLOW-UP

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

STANDARDS:

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

ABD-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

ABD-M MEDICATIONS

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

STANDARDS:

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

ABD-N NUTRITION

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

STANDARDS:

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

ABD-PM PAIN MANAGEMENT

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

STANDARD:

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

ABD-SM STRESS MANAGEMENT

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

STANDARDS:

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

ABD-TE TESTS

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

STANDARDS:

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

ABD-TX TREATMENT

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

STANDARDS:

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

AOD—Alcohol and Other Drugs

AOD-C COMPLICATIONS

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

STANDARDS:

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

AOD-CCA CONTINUUM OF CARE

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

STANDARDS:

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

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

AOD-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

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

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

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

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

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

AOD-DP DISEASE PROCESS

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

STANDARDS:

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

AOD-EX EXERCISE

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

STANDARDS:

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

AOD-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

AOD-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

AOD-M MEDICATIONS

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

STANDARDS:

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

AOD-N NUTRITION

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

STANDARDS:

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

AOD-P PREVENTION

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

STANDARDS:

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

AOD-PLC PLACEMENT

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

STANDARDS:

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

AOD-SCR SCREENING

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

STANDARDS:

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

AOD-SM STRESS MANAGEMENT

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

STANDARDS:

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

AOD-TE TESTS

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

STANDARDS:

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

AOD-WL WELLNESS

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

STANDARDS:

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

AL—Allergies

AL-DP DISEASE PROCESS

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

STANDARDS:

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

AL-FU FOLLOW-UP

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

STANDARDS:

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

AL-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

AL-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

AL-M MEDICATION

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

STANDARDS:

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

AL-N NUTRITION

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

STANDARDS:

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

AL-TE TESTS

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

STANDARDS:

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

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, intrathecals, and reginal 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.

ABX—Antibiotic Resistance

ABX-C COMPLICATIONS

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

STANDARDS:

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

ABX-DP DISEASE PROCESS

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

STANDARDS:

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

ABX-FU FOLLOW-UP

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

STANDARDS:

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

ABX-L LITERATURE

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

STANDARDS:

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

ABX-M MEDICATION

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

STANDARDS:

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

ABX-P PREVENTION

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

STANDARDS:

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

ABX-TE TESTS

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

STANDARDS:

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

ASM—Asthma

ASM-C COMPLICATIONS

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

STANDARDS:

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

ASM-DP DISEASE PROCESS

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

STANDARDS:

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

ASM-EQ EQUIPMENT

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

STANDARDS:

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

ASM-EX EXERCISE

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

STANDARDS:

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

ASM-FU FOLLOW-UP

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

STANDARDS:

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

ASM-HM HOME MANAGEMENT

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

STANDARDS:

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

ASM-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

ASM-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

ASM-M MEDICATIONS

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

STANDARDS:

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

ASM-MDI METERED-DOSE INHALERS

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

STANDARDS:

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

ASM-N NUTRITION

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

STANDARDS:

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

ASM-NEB NEBULIZER

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

STANDARDS:

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

ASM-PF PEAK-FLOW METER

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

STANDARDS:

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

ASM-SHS SECOND-HAND SMOKE

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

STANDARDS:

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

ASM-SPA SPACERS

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

STANDARDS:

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

ASM-TE TESTS

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

STANDARDS:

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

ASM-TO TOBACCO (SMOKING)

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

STANDARDS:

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

ADD—Attention Deficit Hyperactivity Disorder

ADD-DP DISEASE PROCESS

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

STANDARDS:

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

ADD-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept. Discuss prescription medications and how follow-up relates to the ability of the patient to get refills of medications.

ADD-GD GROWTH AND DEVELOPMENT

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

STANDARDS:

1. **Refer to ADD-N.**

ADD-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

ADD-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

ADD-M MEDICATION

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

STANDARDS:

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

ADD-N NUTRITION

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

STANDARDS:

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

ADD-TE TESTS

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

STANDARDS:

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

ADD-TX TREATMENT

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

STANDARDS:

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

B

BF—Breastfeeding

BF-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The parent /family will understand the anatomy and physiology of breastfeeding.

STANDARDS:

1. Explain external anatomy of the breast, including the areola and nipple.
2. Explain internal anatomy of the breast, including milk glands, ducts, milk sinuses.
3. Explain the physiology of breastfeeding, including:
    a. Production of colostrums
    b. Onset of white mature milk within 3-5 days postpartum.
    c. Let down/milk ejection reflex

BF-BB BENEFITS OF BREASTFEEDING

OUTCOME: The parent/family will be able to identify benefits of breastfeeding.

STANDARDS:

1. Identify benefits for mother, including decreased risk of postpartum hemorrhage, enhanced uterine involution, decreased risk of breast cancer, delayed return of menses, improved postpartum weight loss, and bonding.
2. Identify benefits to the baby (i.e., increased IQ, improved bonding, easier to digest)
3. Identify risk reducing benefits to the baby (i.e., reduced risk of: type 1 and type 2 diabetes, obesity, food allergies, infections of mucosal membranes, and constipation).

BF-BC BREAST CARE

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

STANDARDS:

1. Explain the current techniques for management of engorgement and tenderness.
2. Explain some techniques for preventing and managing sore nipples (i.e., assure correct latch-on, apply cool moist tea bags). Refer to BF-ON.
3. Explain the techniques for treating and recognizing signs of infection (mastitis):
    a. need for frequent feeding to reduce risk of breast infections.
    b. need to seek medical care if flu like symptoms (i.e., flu-like symptoms, fever, sores, or redness on breast are present.
    c. need to continue breastfeeding despite infection.
    d. reassure that the baby can continue to safely breast-feed.
4. Explain the techniques for treating and recognizing signs of infection (candida):
    a. keeping the nipples dry helps prevents thrush (i.e., change breast pads often, let nipple air dry).
    b. recognizing the symptoms of thrush (candida), including red painful nipples, characteristic cracking at base of nipple making feeding difficult for the baby. Emphasize the need for medical treatment for both mother and baby to eliminate thrush.
    c. emphasize the need to aggressively clean all items that come in contact with the mother's nipple or the baby's mouth such as clothing, pacifiers, plastic nipples, and breast pump equipment with hot soapy water.
5. Refer to a lactation consultant or other community resources, if available.

BF-BP BREASTFEEDING POSITIONS

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

STANDARDS:

1. Demonstrate the four common breastfeeding positions: cradle, modified cradle (cross-cradle), football, side-lying.
2. Discuss traits of effective positions, including baby parallel to the mom, face to face, tummy to tummy, baby held close to mother.

BF-CS COLLECTION AND STORAGE OF BREASTMILK

OUTCOME: The parent/family will understand the collection and storage of breastmilk.

STANDARDS:

1. Explain the role of manual pumps for occasional use and hospital grade electric pumps for long term use.
2. Explain that pumped breastmilk may have variable appearances and will separate if left standing and will need to be remixed by shaking the milk.
3. Explain storage recommendations for breastmilk, i.e., milk stays good in the refrigerator for 24 hours, refrigerator freezer for 1 month and deep freezer for 3 months.

BF-EQ EQUIPMENT

OUTCOME: The patient/family will understand the instructions for effective use of breast pumps and other breastfeeding equipment.

STANDARDS:

1. Discuss resources for manual and hospital grade electric pumps, including hospital, clinic, WIC, and community.
2. Discuss and demonstrate effective use of pumps.
3. Emphasize the proper use and care and cleaning of equipment.
4. Discuss any other breastfeeding equipment as appropriate.

BF-FU FOLLOW-UP

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

STANDARDS:

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

BF-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent/family will understand the progression of growth and developmental stages of a nursing baby.

STANDARDS:

1. Explain growth and development stages common in a nursing baby, such as:
   a. bonding behaviors
   b. frequent nursing due to growth spurts
   c. eye contact with baby while nursing
   d. baby showing interest in surrounding while nursing
   e. baby gaining independence by crawling and walking
   f. reduced interest in nursing as development progresses

BF-HC HUNGER CUES

OUTCOMES: The parents/family will understand early and late hunger cues and the benefit of responding to early hunger cues.

STANDARDS:

1. Explain early hunger cues, i.e., low intensity cry, small body movements, smacking, rooting.
2. Explain late hunger cues, i.e., high intensity cry, large body movements, arched back, and distressed behavior.
3. Explain that feedings are usually more effectively accomplished at the stage when early hunger cues are being expressed.

BF-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

BF-LA LIFESTYLE ADAPTATIONS

OUTCOME: The parents/family will understand life style adaptations regarding breastfeeding.

STANDARDS:

1. Discuss options for continuing to breastfeeding while separated from the baby, such as with work, school, and hospitalizations.
2. Discuss the reasons for eliminating the exposure of the baby to nicotine, including SIDS and respiratory illness. Encourage the abstinence from nicotine (smoked and chewed). If abstinence is not possible, wait at least one hour after using.
3. Discuss the potentially lethal effects for the baby if a breastfeeding mother uses recreational/street drugs (i.e., particularly drugs such as speed, crystal-meth, amphetamines).
4. Discuss that it is likely to take 2 hours for a nursing mother's body to eliminate the alcohol from the breastmilk if she has a standard serving of an alcohol containing beverage. A standard serving is typically 12 ounces of beer, one shot of liquor, or 4-5 ounces of wine.
5. Discuss options for breastfeeding in public.
6. Identify community resources available for breastfeeding support (i.e., La Leche League, WIC, community health nursing breastfeeding educators, IHS Breastfeeding Hotline 1-877-868-9473).

BF-M MATERNAL MEDICATIONS

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

STANDARDS:

1. Explain that most OTC and prescribed medications are safe in breastfeeding, but the breastfeeding mother should consult a health care provider before starting any new prescribed or OTC medications and/or herbal/traditional therapies.
2. Explain that there are a few substances that are harmful, including, but not limited to, recreational/street drugs, some anticonvulsants, some antidepressants, chemotherapeutic agents, radio-pharmaceuticals, etc. (Note: this information is subject to change and current resources should be consulted before counseling a patient about any medication).

BF-MK MILK INTAKE

OUTCOME: The parent/family will understand the signs of adequate milk intake.

STANDARDS:

1. Explain the feeding duration should be at least 15 minutes on each side, encouraging the baby to nurse longer as the baby desires. Feeding will take less time as the baby grows.
2. Explain the feeding frequency should be an average of every 2-3 hours, 8-10 times in 24 hours in the first weeks. Feeding will spread out as the baby grows.
3. Explain diaper change patterns in the first week beginning with a few diapers each day to at least 6-8 diapers changes in 24 hours by 1 week of age.
4. Explain transition of stool from meconium to transitional stool (brown, mushy) to breastfed stool (yellow with white seeds) when the white, mature milk comes in.

BF-NJ NEONATAL JAUNDICE

OBJECTIVE: The family will understand the importance of monitoring for jaundice and the complications of unrecognized jaundice.

STANDARDS:

1. Explain that jaundice is the yellow color seen in the skin of many newborns which is caused by build up of bilirubin in the blood.
2. Explain that everyone's blood contains bilirubin, which is removed by the liver and that before birth, the mother's liver does this for the baby. Explain that many babies develop jaundice in the first few days after birth because it takes a few days for the baby's liver to get better at removing bilirubin.
3. Explain that the yellow skin color caused by bilirubin usually appears first in the face then moves to the chest, abdomen, arms and legs as the bilirubin level increases. Explain that the whites of the eyes may also be yellow.
4. Explain that mild jaundice is harmless but high levels of bilirubin may cause brain damage.
5. Explain that this brain damage can be prevented by treatment of the jaundice before the bilirubin level gets too high. Discuss that treatment options may include medical phototherapy or exchange transfusion.
6. Emphasize that parents should watch closely for jaundice and seek medical attention if jaundice is noticed.
7. Explain that medical personnel can check the level of bilirubin in the blood by blood tests or occasionally by a skin test.
8. Explain that all bilirubin levels must be interpreted in light of the infant's age and that term infants and older infants can tolerate higher levels of bilirubin than preterm infants and younger infants.
9. Explain that jaundice is more common in breastfed infants especially when the infant is not nursing well. Encourage nursing the infant a minimum of 8-12 times a day for the first week of life to increase milk production and keep bilirubin levels down. Emphasize that breastmilk is the ideal food for infants.

BF-N NUTRITION (MATERNAL)

OUTCOME: The parent/family will understand the foods that contribute to the nutritional well-being of breastfeeding mothers.

STANDARDS

1. Encourage consumption of same kinds of foods that are important during pregnancy.
2. Identify foods to avoid if necessary (i.e., chocolate, gas forming food, and highly seasoned foods).
3. Emphasize the increased need for water in the diet of breastfeeding mothers.

BF-ON LATCH-ON

OUTCOME: The parent/family will understand the characteristics of effective latch.

STANDARDS:

1. Identify the cues that indicate readiness to feed, i.e., wakefulness, lip smacking, and rooting.
2. Explain that effective latch on will be more successful if the baby's mouth is open wide.
3. Explain the physical traits of an effective latch (i.e., both lips out- covering at least part of the areola, with absence of chomping by baby and absence of prolonged pain for the mother).

BF-SF INTRODUCTION TO SOLID FOODS

OUTCOME: The parent/family will understand the appropriate ages to introduce various solid foods. (teach any or all of the following as appropriate to this infant/family)

STANDARDS:

1. Explain that infants should not routinely be fed foods other than breastmilk or formula prior to 4 months of age except under the advice of a healthcare provider.
2. Emphasize that, for some time after the introduction of solid foods, breastmilk/formula will still be the infant's primary source of nutrition.
3. Emphasize that foods should never be given from a bottle or infant feeder and must always be fed from a spoon.
4. Explain that infants may be fed cereal mixed with breastmilk or formula not sooner than 4 months of age. Rice cereal is generally the preferred first solid food. It is normal for an infant to take very small amounts of solid foods for several months. Discard any uneaten food after each meal.
5. Emphasize the need to wait 3-5 days between the addition of new foods to watch for adverse events from the foods.
6. Explain that pureed/or finely mashed vegetables and fruits should be started no earlier than 6 months of age.
7. Explain that some foods such as peanut butter, chocolate, eggs, strawberries, cow or goat milk and citrus should not be fed until the infant is one year of age due to the highly allergenic nature of these foods. Explain that honey and syrups may contain botulism toxin and should not be fed before one year of age.
8. Explain that infants 14-16 moths of age will have a decreased appetite and will become more picky eaters.
9. Emphasize that some foods are easy to choke on and should be avoided until 4 years of age, i.e., nuts, hard candies, gum, carrot sticks, meat on a bone, grapes, popcorn, hot dogs, unpeeled apples, slices of orange.
10. Discuss the importance of offering foods at the appropriate ages but do not insist that infants eat foods when they are not hungry:
    a. Baby knows how much to eat
    b. It is important to go along with the baby when they feel they have finished eating
    c. Some days babies eat a lot other days not as much
    d. No two babies eat the same
11. Explain how to assess readiness, an infant:
    a. who exhibits tongue thrusting is not ready to eat solids.

b. will give you cues to readiness when they open their mouths when they see something coming

c. will close lips over a spoon

d. will keep food in their mouth instead of spitting it out

e. will sit up alone without support

12. Explain that the body of knowledge regarding infant feedings has changed dramatically and advice from family/friends may no longer be appropriate; talk to your healthcare provider.

BF-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress may result in problems with milk let-down and reduced milk supply.
2. Explain that effective stress management may increase the success of breastfeeding.
3. Explain that difficulty with breastfeeding may result in feelings of inadequacy, low self-esteem, or failure as a mother.
4. Emphasize the importance of seeking help (i.e., lactation consultant, public health nurse or other nurse, WIC) as needed to improve breastfeeding success and reduce stress.
5. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use which may reduce the ability to breast-feed successfully.
6. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. recruiting other family members or friends to help with child care
    d. talking with people you trust about your worries or problems
    e. setting realistic goals
    f. getting enough sleep (e.g., sleeping when the baby sleeps if possible)
    g. maintaining a reasonable diet
    h. exercising regularly
    i. 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.

BF-T TEETHING

OUTCOME: The parent/family will understand teething behaviors and ways to prevent biting while breastfeeding.

STANDARDS:

1. Explain the normal stages of teething, i.e., sore swollen gums and the baby's tendency to nurse to ease discomfort.
2. Identify ways to anticipate and prevent biting in a teething baby (i.e., closely observing the baby while nursing to interrupt potential biting).
3. Explain the variety of techniques to discourage persistent biting (i.e., keeping finger poised near baby's mouth to interrupt chomping, briefly stopping the feeding, firmly say "no" and break the latch.

BF-W WEANING

OUTCOME: The parent/family will understand methods to effectively wean the child from breastfeeding.

STANDARDS:

1. Discuss reasons for weaning (i.e., including infant/child readiness, separation from mother, medication needed for mother that is contraindicated in breastfeedings).
2. Explain process of weaning, including replacing one feeding at a time with solids or milk from cup.
3. Explain managing abrupt weaning to prevent/reduce the risk of breast infections, such as pumping/expressing to comfort.
4. Explain social ways to replace breastfeeding such as reading books together at the table and playing with toys.
5. Refer to community resources as appropriate.

BURN—Burns

BURN-C COMPLICATIONS

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

STANDARDS:

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

BURN-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

BURN-DP DISEASE PROCESS

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

STANDARDS:

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

BURN-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

BURN-P PREVENTION

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

STANDARDS:

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

(3) Use cool water humidifiers not steam vaporizers

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

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

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

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

d. To prevent electrical burns:

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

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

(3) Don't overload outlets

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

(5) Don't modify electrical cords or plugs

(6) Use power surge protectors

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

BURN-TX TREATMENT

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

STANDARDS:

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

BURN -WC WOUND CARE

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

STANDARDS:

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

C

CD—Chemical Dependency

Refer to AOD-Alcohol and Other Drugs.

CP—Chest Pain

CP-DP DISEASE PROCESS

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

STANDARDS:

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

CP-EQ EQUIPMENT

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

STANDARDS:

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

CP-FU FOLLOW-UP

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

STANDARDS:

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

CP-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

CP-M MEDICATIONS

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

STANDARDS:

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

CP-N NUTRITION

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

STANDARDS:

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

CP-SM STRESS MANAGEMENT

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

STANDARDS:

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

CP-TE TESTS

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

STANDARDS:

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

CHN—Child Health – Newborn (0-60 Days)

CHN-FU FOLLOW-UP

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

STANDARDS:

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

CHN-GD GROWTH AND DEVELOPMENT

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

STANDARDS:

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

CHN-I INFORMATION

OUTCOME: Parents/family will understand newborn health and wellness issues.

STANDARDS:

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

CHN-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

CHN-NJ NEONATAL JAUNDICE

OBJECTIVE: The family will understand the importance of monitoring for jaundice and the complications of unrecognized jaundice.

STANDARDS:

1. Explain that jaundice is the yellow color seen in the skin of many newborns which is caused by build up of bilirubin in the blood.
2. Explain that everyone's blood contains bilirubin, which is removed by the liver and that before birth, the mother's liver does this for the baby. Explain that many babies develop jaundice in the first few days after birth because it takes a few days for the baby's liver to get better at removing bilirubin.
3. Explain that the yellow skin color caused by bilirubin usually appears first in the face then moves to the chest, abdomen, arms and legs as the bilirubin level increases. Explain that the whites of the eyes may also be yellow.
4. Explain that mild jaundice is harmless but high levels of bilirubin may cause brain damage.
5. Explain that this brain damage can be prevented by treatment of the jaundice before the bilirubin level gets too high. Discuss that treatment options may include medical phototherapy or exchange transfusion.
6. Emphasize that parents should watch closely for jaundice and seek medical attention if jaundice is noticed.
7. Explain that medical personnel can check the level of bilirubin in the blood by blood tests or occasionally by a skin test.
8. Explain that all bilirubin levels must be interpreted in light of the infant's age and that term infants and older infants can tolerate higher levels of bilirubin than preterm infants and younger infants.
9. Explain that jaundice is more common in breastfed infants especially when the infant is not nursing well. Encourage nursing the infant a minimum of 8-12 times a day for the first week of life to increase milk production and keep bilirubin levels down. Emphasize that breastmilk is the ideal food for infants.

CHN-N NUTRITION

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

STANDARDS:

1. Encourage breastfeeding as the healthy way to feed infants. Explain that infants grow appropriately on formula when breastfeeding is not an option. **Refer to BF**.
2. Discuss that solids are not needed until 4-6 months of age.
3. Discourage the use of cereals added to formula except when specifically recommended by the health care provider.
4. Emphasize that nothing should be given from the bottle but formula, breastmilk, water, or electrolyte solutions, i.e., no caffeinated beverages or other soft drinks.
5. Review formula preparation and storage of formula and/or breastmilk as appropriate.
6. Review proper technique and position for bottle feeding, i.e., no propping of bottles.

CHN-PA PARENTING

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

STANDARDS:

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

CHN-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

1. Review the dangers of leaving a newborn unattended. Discuss the need to require ID from people presenting themselves in an official capacity.
2. Stress the use of a properly secured, rear facing car seat EVERY TIME the newborn rides in a vehicle. The car seat should be in the middle of the back seat of the vehicle.
3. Discuss the requirement of a NTSB approved car seat. Not all infant carriers are approved for use in automobiles.
4. Discuss the dangers posed by--open flames, closed-up cars, siblings, plastic bags, tossing the baby in the air, second-hand cigarette smoke and shaken-baby syndrome.
5. Illustrate the proper way to support a newborn's head and back.
6. Explain that SIDS is decreased by back or side-lying and by not smoking in the home or car.
7. Stress the importance of carefully selecting child-care settings to assure child safety.
8. Discuss the importance of keeping a hand on the infant when he/she is lying on any surface over floor level to avoid falls.
9. Discuss the dangers posed by hot liquids, too hot bath water, microwaving baby bottles, and cigarettes or open flames.

CHN-SF INTRODUCTION TO SOLID FOODS

OUTCOME: The parent/family will understand the appropriate ages to introduce various solid foods. (teach any or all of the following as appropriate to this infant/family)

STANDARDS:

1. Explain that infants should not routinely be fed foods other than breastmilk or formula prior to 4 months of age except under the advice of a healthcare provider.
2. Emphasize that, for some time after the introduction of solid foods, breastmilk/formula will still be the infant's primary source of nutrition.
3. Emphasize that foods should never be given from a bottle or infant feeder and must always be fed from a spoon.
4. Explain that infants may be fed cereal mixed with breastmilk or formula not sooner than 4 months of age. Rice cereal is generally the preferred first solid food. It is normal for an infant to take very small amounts of solid foods for several months. Discard any uneaten food after each meal.
5. Emphasize the need to wait 3-5 days between the addition of new foods to watch for adverse events from the foods.
6. Explain that pureed/or finely mashed vegetables and fruits should be started no earlier than 6 months of age.
7. Explain that some foods such as peanut butter, chocolate, eggs, strawberries, cow or goat milk and citrus should not be fed until the infant is one year of age due to the highly allergenic nature of these foods. Explain that honey and syrups may contain botulism toxin and should not be fed before one year of age.
8. Explain that infants 14-16 moths of age will have a decreased appetite and will become more picky eaters.
9. Emphasize that some foods are easy to choke on and should be avoided until 4 years of age, i.e., nuts, hard candies, gum, carrot sticks, meat on a bone, grapes, popcorn, hot dogs, unpeeled apples, slices of orange.
10. Discuss the importance of offering foods at the appropriate ages but do not insist that infants eat foods when they are not hungry:
    a. Baby knows how much to eat
    b. It is important to go along with the baby when they feel they have finished eating
    c. Some days babies eat a lot other days not as much
    d. No two babies eat the same
11. Explain how to assess readiness, an infant:
    a. who exhibits tongue thrusting is not ready to eat solids.

b. will give you cues to readiness when they open their mouths when they see something coming

c. will close lips over a spoon

d. will keep food in their mouth instead of spitting it out

e. will sit up alone without support

12. Explain that the body of knowledge regarding infant feedings has changed dramatically and advice from family/friends may no longer be appropriate; talk to your healthcare provider.

CHN-SHS SECOND-HAND SMOKE

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

STANDARDS:

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

CHI—Child Health – Infant (2-12 Months)

CHI-FU FOLLOW UP

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

STANDARDS:

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

CHI-GD GROWTH AND DEVELOPMENT

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

STANDARDS:

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

CHI-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

CHI-N NUTRITION

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

STANDARDS:

1. Discuss the schedule for introducing solids and juices at 4-6 months of age, and how to accomplish first spoon feeding. Explain that solids should not be fed from a bottle or infant feeder but from a spoon.
2. Review breastfeeding and discuss current information on the use of vitamin and iron supplements when breastfeeding.
3. Review formula preparation and storage and proper technique and position for bottle feeding (no propping bottles in bed).
4. Discuss age appropriate intake (ounces/day) and stress the dangers of overfeeding.
5. Discuss weaning, transition from bottle to cup. Emphasize the effects of "baby bottle tooth decay".
6. Discuss waiting 3-4 days between additions of new foods to identify food allergies.
7. Discuss as appropriate the recommendations for fluoride supplementation in non-fluoridated water areas. (Currently no fluoride supplementation is recommended for infants under 6 months of age.)
8. Explain the dangers of giving honey before the age of one year. (infantile botulism)
9. Emphasize the importance of avoiding food that are easy to choke on, i.e., nuts, hard candy, gum.
10. Emphasize the importance of observing the child while eating to reduce the risk of choking.
11. Emphasize the importance of having the child remain seated while eating to reduce the risk of choking.

CHI-PA PARENTING

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

STANDARDS:

1. Discuss how home life is beginning to settle down. Encourage the parents to find some time to nurture their relationship.
2. Review basic nurturing skills: spending time with the infant, continued importance of touch, involving father in care and nurturing.
3. Discuss age appropriate disciplinary techniques as increasing mobility increases the risk of injury (i.e., distraction for the 6 month old).
4. Encourage stimulation of the infant (auditory, tactile, visual).
5. Encourage sibling participation in care of the infant.
6. Discuss the role of a bedtime routine and comfort objects such as stuffed animals or blankets as appropriate to the age of the infant.
7. Stress importance of regular well child care and immunizations.
8. Review the community resources available for help in coping with an infant.

CHI-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

1. Explain that accidents are a major cause of death.
2. Emphasize the importance of a properly fitting car seat correctly installed, rear facing until one year of age and the correct place in the car (currently the middle of the back seat for the youngest child).
3. Stress that the infant's increasing mobility requires additional vigilance to the dangers of aspiration, suffocation, falls, poisonings, burns, motor vehicle crashes and other accidents.
4. Explain that walkers are a source of serious injury and often delay walking.
5. Explain that SIDS is decreased by back or side lying and by not smoking in the home or car.
6. Child-proof the home. **Refer to WL-S**.
    a. Keep hot liquids, cigarettes and other hot objects out of the infant's reach and cover outlets to avoid burns, i.e., turn pot handles to the back of the stove and use back burners preferentially.
    b. Review choking hazards and the importance of keeping small objects out of the child's reach.
    c. Review drowning and the importance of never leaving the child unattended in the bath and keeping toilet lids down and bathroom doors closed.
    d. Emphasize the importance of child locks on cabinets and keeping potentially dangerous substances and objects out of the child's reach.
    e. Emphasize the importance of keeping electrical cords and other wiring out of the reach of children. Small children will chew and pull on electrical cords and wiring.
7. Emphasize the importance of carefully selecting child-care settings to assure child safety.

CHI-SF INTRODUCTION TO SOLID FOODS

OUTCOME: The parent/family will understand the appropriate ages to introduce various solid foods. (teach any or all of the following as appropriate to this infant/family)

STANDARDS:

1. Explain that infants should not routinely be fed foods other than breastmilk or formula prior to 4 months of age except under the advice of a healthcare provider.
2. Emphasize that, for some time after the introduction of solid foods, breastmilk/formula will still be the infant's primary source of nutrition.
3. Emphasize that foods should never be given from a bottle or infant feeder and must always be fed from a spoon.
4. Explain that infants may be fed cereal mixed with breastmilk or formula not sooner than 4 months of age. Rice cereal is generally the preferred first solid food. It is normal for an infant to take very small amounts of solid foods for several months. Discard any uneaten food after each meal.
5. Emphasize the need to wait 3-5 days between the addition of new foods to watch for adverse events from the foods.
6. Explain that pureed/or finely mashed vegetables and fruits should be started no earlier than 6 months of age.
7. Explain that some foods such as peanut butter, chocolate, eggs, strawberries, cow or goat milk and citrus should not be fed until the infant is one year of age due to the highly allergenic nature of these foods. Explain that honey and syrups may contain botulism toxin and should not be fed before one year of age.
8. Explain that infants 14-16 moths of age will have a decreased appetite and will become more picky eaters.
9. Emphasize that some foods are easy to choke on and should be avoided until 4 years of age, i.e., nuts, hard candies, gum, carrot sticks, meat on a bone, grapes, popcorn, hot dogs, unpeeled apples, slices of orange.
10. Discuss the importance of offering foods at the appropriate ages but do not insist that infants eat foods when they are not hungry:
    a. Baby knows how much to eat
    b. It is important to go along with the baby when they feel they have finished eating
    c. Some days babies eat a lot other days not as much
    d. No two babies eat the same
11. Explain how to assess readiness, an infant:
    a. who exhibits tongue thrusting is not ready to eat solids.

b. will give you cues to readiness when they open their mouths when they see something coming

c. will close lips over a spoon

d. will keep food in their mouth instead of spitting it out

e. will sit up alone without support

12. Explain that the body of knowledge regarding infant feedings has changed dramatically and advice from family/friends may no longer be appropriate; talk to your healthcare provider.

CHI-SHS SECOND-HAND SMOKE

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

STANDARDS:

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

CHI - W WEANING

OUTCOME: The parent/family will understand methods to effectively wean the child from breastfeeding or bottle.

STANDARDS:

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

CHT—Child Health – Toddler (1-3 Years)

CHT-FU FOLLOW-UP

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

STANDARDS:

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

CHT-GD GROWTH AND DEVELOPMENT

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

STANDARDS:

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

CHT-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

CHT-N NUTRITION

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

STANDARDS:

1. Discuss the varying levels of mastery of cups and utensils. Allow the toddler to feed him/herself.
2. Discuss the importance of eating meals as a family and providing 2-3 nutritious snacks per day. Encourage a relaxed mealtime atmosphere.
3. Review the dangers posed by continued use of the bottle beyond one year of age, i.e., baby bottle tooth decay, elongated midface, delayed speech, ear infections. **Refer to OM-P and ECC-P**.
4. Explain that most toddlers manifest a decreased nutritional need. Discuss that toddlers become fussy eaters with strong food preferences. Discuss appropriate diet (balance diet over the week -- do not struggle to balance every meal,).
5. Discuss the need for whole milk at least through 2 years of age and encourage low fat milk after the age of 2.
6. Avoid foods that are choking hazards through age 4 (unpeeled grapes, unpeeled apples, orange slices, nuts, popcorn, pickles, carrot sticks, celery sticks, hard candies and gum, wieners, chicken drum sticks, and peanut butter).
7. Encourage and model healthy choices for meals and snacks (e.g., fruit, veggies, lean meats, and whole grains). Limit foods such as candies, cookies, etc.

CHT-PA PARENTING

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

STANDARDS:

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

CHT-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

1. Review that accidents are the leading cause of death in this age group due to the toddler's increased mobility and lack of awareness of environmental dangers. Child-proof the home. Check windows and screens to assure that the toddler cannot push them out, etc.
2. Stress additional vigilance to the dangers of drowning, open flames, charcoal pans, aspiration, suffocation, falls, poisonings, animal bites, electrocution and motor vehicle crashes. **Refer to WL-S.**
3. Discuss foods which are choking hazards (unpeeled grapes, unpeeled apples, orange slices, nuts, popcorn, pickles, carrot sticks, celery sticks, hard candies and gum, hot dogs, any meat on a bone, and peanut butter).
4. Discuss other choking hazards (i.e., balloons, coins, toys that will fit inside a toilet paper roll, and latex gloves).
5. Review continued need for child safety seats in automobiles. (As of November 2004 the American Academy of Pediatrics recommends that children remain in child safety seats until the age of 8 years AND 80 pounds.)
6. Review the need for bicycle helmets when riding on a tricycle, bicycle or with a parent on a bicycle.
7. Discourage independent operation of any motorized vehicle, including electrical vehicles.
8. Review the continued need to check water temperature for baths and to never leave the child unattended when near water.
9. Discuss the use of sunscreen while outdoors. **Refer to SUN.**
10. Emphasize the importance of carefully selecting child-care settings to assure child safety.

CHT-SF INTRODUCTION TO SOLID FOODS

OUTCOME: The parent/family will understand the appropriate ages to introduce various solid foods. (teach any or all of the following as appropriate to this infant/family)

STANDARDS:

1. Explain that infants should not routinely be fed foods other than breastmilk or formula prior to 4 months of age except under the advice of a healthcare provider.
2. Emphasize that, for some time after the introduction of solid foods, breastmilk/formula will still be the infant's primary source of nutrition.
3. Emphasize that foods should never be given from a bottle or infant feeder and must always be fed from a spoon.
4. Explain that infants may be fed cereal mixed with breastmilk or formula not sooner than 4 months of age. Rice cereal is generally the preferred first solid food. It is normal for an infant to take very small amounts of solid foods for several months. Discard any uneaten food after each meal.
5. Emphasize the need to wait 3-5 days between the addition of new foods to watch for adverse events from the foods.
6. Explain that pureed/or finely mashed vegetables and fruits should be started no earlier than 6 months of age.
7. Explain that some foods such as peanut butter, chocolate, eggs, strawberries, cow or goat milk and citrus should not be fed until the infant is one year of age due to the highly allergenic nature of these foods. Explain that honey and syrups may contain botulism toxin and should not be fed before one year of age.
8. Explain that infants 14-16 moths of age will have a decreased appetite and will become more picky eaters.
9. Emphasize that some foods are easy to choke on and should be avoided until 4 years of age, i.e., nuts, hard candies, gum, carrot sticks, meat on a bone, grapes, popcorn, hot dogs, unpeeled apples, slices of orange.
10. Discuss the importance of offering foods at the appropriate ages but do not insist that infants eat foods when they are not hungry:
    a. Baby knows how much to eat
    b. It is important to go along with the baby when they feel they have finished eating
    c. Some days babies eat a lot other days not as much
    d. No two babies eat the same
11. Explain how to assess readiness, an infant:
    a. who exhibits tongue thrusting is not ready to eat solids.

b. will give you cues to readiness when they open their mouths when they see something coming

c. will close lips over a spoon

d. will keep food in their mouth instead of spitting it out

e. will sit up alone without support

12. Explain that the body of knowledge regarding infant feedings has changed dramatically and advice from family/friends may no longer be appropriate; talk to your healthcare provider.

CHT-SHS SECOND-HAND SMOKE

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

STANDARDS:

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

CHT-W WEANING

OUTCOME: The parent/family will understand methods to effectively wean the child from breastfeeding or bottle.

STANDARDS:

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

CHP—Child Health – Preschool (3-5 Years)

CHP-FU FOLLOW UP

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

STANDARDS:

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

CHP-GD GROWTH AND DEVELOPMENT

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

STANDARDS:

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

CHP-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

CHP-N NUTRITION

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

STANDARDS:

1. Review the basics of a balanced diet. Explain that serving sizes for children are smaller than for adults.
2. Encourage family meal times and healthy snacks between meals.
3. Discuss the relationships between childhood obesity and adult obesity. Relate the risk of diabetes to obesity.
4. Emphasize the importance of healthy snack foods, limit fatty foods and refined sugars, increase fresh fruits, fresh vegetables and fiber.
5. Explain the need for a structured meal time due to short attention span and high mobility.
6. Explain that this is a critical age when children form their eating habits. Encourage the parents to model eating habits that are essential to developing a healthy weight.

CHP-PA PARENTING

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

STANDARDS:

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

CHP-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

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

CHP-SHS SECOND-HAND SMOKE

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

STANDARDS:

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

CHS—Child Health School Age (5-12 Years)

CHS-FU FOLLOW-UP

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

STANDARDS:

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

CHS-GD GROWTH AND DEVELOPMENT

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

STANDARDS:

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

CHS-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

CHS-N NUTRITION

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

STANDARDS:

1. Review the basics of a balanced diet. Teach the child to make healthy food choices. Avoid foods high in fat and sugar.
2. Encourage parents to read food and beverage labels and then make healthy choices.
3. Emphasize that high fructose corn syrup is widely used to sweeten prepared foods and beverages and contributes to obesity.
4. Discuss how childhood obesity is increasingly prevalent in school-aged children and emphasize its relationship to adult obesity and emotional well-being. Relate the risk of diabetes to obesity.
5. Discuss the child's predilection for junk food. Stress ways to improve the diet by replacing empty calories with fresh fruits, nuts and other wholesome snacks.
6. Encourage parents to model healthy nutritional habits and to eat as a family as often as possible.

CHS-PA PARENTING

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

STANDARDS:

1. Discuss how peer influence becomes increasingly important.
2. Review age-specific changes:
   a. Age 6: Mood changes, need for privacy
   b. Age 7-10: Increase in peer involvement. Experimentation with potentially harmful activities and substances may begin.
   c. Age 11-12: Increase in stormy behavior. Sexual maturation necessitates adequate and accurate sex education.
3. Provide stimulating activities as an alternative to watching TV, playing video games, and other sedentary activities. Sedentary activities should be limited to one hour per day.
4. Discuss the importance of listening to the school aged child and showing interest in his/her activities.
5. Emphasize the importance of knowing the child's friends and their families.
6. Discuss that drinking and smoking in the presence of children may promote this behavior in the child.

CHS-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

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

CHS-SHS SECOND-HAND SMOKE

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

STANDARDS:

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

CHS-SX SEXUALITY

OUTCOME: The parent(s) and preadolescent will understand that children are maturing at an earlier age, necessitating education about sexual safety at an earlier age.

STANDARDS:

1. Explain the physical changes that result from increased hormonal activity. Discuss that this is happening at a earlier age and may produce an expectation of a more mature behavior which is often unrealistic.
2. Discuss that early maturity can often lead to self esteem issues (i.e., depression, isolation, unrealistic body image, eating disorders, and sexual promiscuity).
3. Discuss as appropriate the anatomy and physiology of the male/female reproductive tract. **Refer to WL-SX**.
4. Explain that as a general rule, menarche occurs within two years of thelarche (breast development).
5. Discuss the elements of a positive, nurturing interpersonal relationship versus a potentially abusive relationship.
6. Review the physical and emotional benefits of and encourage abstinence (i.e., self-respect, negating the risk of STIs, and pregnancy, dramatically reducing the risk of cervical cancer, having the first sexual encounter be in the context of a stable, loving relationship).
7. Identify the community resources available for sexuality counseling.

CHS-TO TOBACCO

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

STANDARDS:

1. Review the current factual information regarding tobacco use. Explain that tobacco use in any form is dangerous.
2. Explain nicotine addiction.
3. Discuss the common problems associated with tobacco use and the long term effects of continued use of tobacco, i.e., COPD, cardiovascular disease, numerous kinds of cancers including lung cancer.
4. Review the effects of tobacco use on all family members- financial burden, second-hand smoke, greater risk of fire and premature.
5. Explain dependency and co-dependency.
6. Discuss that tobacco use is a serious threat to health. If the patient is already using tobacco, encourage tobacco cessation and refer to cessation program. **Refer to TO.**

CHA—Child Health – Adolescent (12-18 Years)

CHA-AOD ALCOHOL AND OTHER DRUGS

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

STANDARDS:

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

4. Explain that alcohol use is a major cause of illness and death in the United States and that addiction is common. Some of the risks of alcohol use are:
    a. Significant impairment of judgment and thinking ability leading to behaviors which the patient might not otherwise engage in, such as indiscriminate sex, fighting, and use of other drugs.
    b. Liver disease, up to and including complete liver failure and death.
    c. Arrest and imprisonment for alcohol-related behaviors such as drunken driving or fighting.
    d. Loss of employment, destroyed relationships with loved ones, and serious financial problems.

CHA-FU FOLLOW-UP

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

STANDARDS:

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

CHA-GD GROWTH AND DEVELOPMENT

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

STANDARDS:

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

CHA-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

CHA-N NUTRITION

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

STANDARDS:

1. Stress the importance of reducing fats, sugars, and starch to avoid obesity and diabetes and subsequent self-image problems. Emphasize the role peers play in food intake. **Refer to WL-N**.
2. Emphasize the importance of not skipping meals, especially breakfast.
3. Discuss calcium intake, including its role in preventing osteoporosis.
4. Discuss the risk of anorexia and bulimia in adolescence. Discuss signs of these diseases as appropriate.

CHA-PA PARENTING

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

STANDARDS:

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

CHA-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

1. **Refer to AOD and TO**.
2. Promote driving education courses and the importance of following the speed limit and other rules of the road
3. Promote use of seat belts and other personal protective equipment, i.e., helmets, knee pads, elbow pads, mouth guards.
4. Promote the safe use of all recreational vehicles (i.e., all terrain vehicles (ATVs), snow machines, boats, horses), refer to community resources as appropriate.
5. Discourage sun tanning or use of tanning beds. Encourage the use of sunscreen to decrease the risk of skin cancer. **Refer to SUN**.
6. Review personal safety strategies, i.e., sexual molestation, strangers, chat rooms.
7. Review self-destructive behaviors (suicidal gestures and comments, improper/inappropriate use of firearms, gangs, cults, hazing, alcohol and substance use/abuse).

CHA-SHS SECOND-HAND SMOKE

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

STANDARDS:

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

CHA-SX SEXUALITY

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

STANDARDS:

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

CHA-TO TOBACCO

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

STANDARDS:

1. Review the current factual information regarding tobacco use. Explain that tobacco use in any form is dangerous.
2. Explain nicotine addiction.
3. Discuss the common problems associated with tobacco use and the long term effects of continued use of tobacco, i.e., COPD, cardiovascular disease, numerous kinds of cancers including lung cancer.
4. Review the effects of tobacco use on all family members: financial burden, second-hand smoke, greater risk of fire and premature death.
5. Explain dependency and co-dependency.
6. Discuss that tobacco use is a serious threat to health. If the patient is already using tobacco, encourage tobacco cessation and refer to cessation program. **Refer to TO.**

CDC—Communicable Diseases

CDC-DP DISEASE PROCESS

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

STANDARDS:

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

CDC-FU FOLLOW-UP

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

STANDARDS:

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

CDC-HM HOME MANAGEMENT

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

STANDARDS:

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

CDC-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

CDC - M MEDICATION

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

STANDARDS:

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

CDC-N NUTRITION

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

STANDARDS:

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

CDC-P PREVENTION

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

STANDARDS:

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

CDC-PM PAIN MANAGEMENT

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

STANDARDS:

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

CDC-TE TESTS

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

STANDARDS:

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

CRP—Croup

CRP-C COMPLICATIONS

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

STANDARDS:

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

CRP-DP DISEASE PROCESS

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

STANDARDS:

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

CRP-EQ EQUIPMENT

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

STANDARDS:

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

CRP-FU FOLLOW-UP

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

STANDARDS:

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

CRP-HM HOME MANAGEMENT

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

STANDARDS:

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

CRP-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

CRP-M MEDICATIONS

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

STANDARDS:

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

CRP-SHS SECOND-HAND SMOKE

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

STANDARDS:

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

CF—Cystic Fibrosis

CF-C COMPLICATIONS

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

STANDARDS:

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

CF-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.

CF-DP DISEASE PROCESS

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

STANDARDS:

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

CF-EQ EQUIPMENT

OUTCOME: The patient/family will understand any medical equipment utilized by this patient.

STANDARDS:

1. Discuss indications for and benefits of prescribed medical equipment.
2. Discuss types and features of medical equipment as appropriate.
3. Discuss and/or demonstrate proper use and care of medical equipment, participate in return demonstration by patient/family.
4. Discuss signs of equipment malfunction and proper action incase of malfunction.
5. Emphasize safe use of equipment, i.e., no smoking around O2 use of gloves, electrical cord safety, and disposal of sharps.

CF-FU FOLLOW-UP

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

STANDARDS:

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

CF-L PATIENT LITERATURE INFORMATION

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

STANDARDS:

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

CF-N NUTRITION

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

STANDARDS:

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

CF-SHS SECOND HAND SMOKE

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

STANDARDS:

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

CF-TE TESTS

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

STANDARDS:

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

CF-TO TOBACCO (SMOKING)

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

STANDARDS:

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

CF-TX TREATMENT

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

STANDARDS:

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

D

DEH—Dehydration

DEH-C COMPLICATIONS

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

STANDARDS:

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

DEH-DP DISEASE PROCESS

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

STANDARDS:

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

DEH-EQ EQUIPMENT

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

STANDARDS:

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

DEH-FU FOLLOW-UP

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

STANDARDS:

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

DEH-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

DEH-P PREVENTION

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

STANDARDS:

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

DEH-TE TESTS

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

STANDARDS:

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

DEH-TX TREATMENTS

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

STANDARDS:

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

DC—Dental Caries

DC-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

DC-C COMPLICATIONS

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

STANDARDS:

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

DC-DP DISEASE PROCESS

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

STANDARDS:

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

DC-FU FOLLOW-UP

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

STANDARDS:

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

DC-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

DC-N NUTRITION

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

STANDARDS:

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

DC-P PREVENTION

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

STANDARDS:

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

DC-PM PAIN MANAGEMENT

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

DC-TE TESTS

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

STANDARDS:

1. Discuss the test(s) to be performed, i.e., x-ray, pulp vitality.
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment. Discuss the risks of non-performance of the testing.

DC-TX TREATMENT

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

STANDARDS:

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

DV—Domestic Violence

DV-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

DV-DP DISEASE PROCESS

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

STANDARDS:

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

DV-FU FOLLOW-UP

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

STANDARDS:

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

DV-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

DV-P PREVENTION

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

STANDARDS:

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

DV-PSY PSYCHOTHERAPY

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

STANDARDS:

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

DV-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

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

DV-SCR SCREENING

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

STANDARDS

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

DV-SM STRESS MANAGEMENT

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

STANDARDS:

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

DV-TX TREATMENT

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

STANDARDS:

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

DYS—Dysrhythmias

DYS-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

DYS-C COMPLICATIONS

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

STANDARDS:

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

DYS-DP DISEASE PROCESS

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

STANDARDS:

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

DYS-EQ EQUIPMENT

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

STANDARDS:

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

DYS-FU FOLLOW-UP

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

STANDARDS:

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

DYS-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

DYS-M MEDICATIONS

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

STANDARDS:

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

DYS-PRO PROCEDURES

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

STANDARDS:

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

DYS-TE TESTS

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

STANDARDS:

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

DYS-TX TREATMENT

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

STANDARDS:

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

E

ECC—Early Childhood Caries

ECC-C COMPLICATIONS

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

STANDARDS:

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

ECC-DP DISEASE PROCESS

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

STANDARDS:

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

ECC-FU FOLLOW-UP

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

STANDARDS:

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

ECC-GD GROWTH AND DEVELOPMENT

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

STANDARDS:

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

ECC-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

ECC-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

ECC-N NUTRITION

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

STANDARDS:

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

ECC-P PREVENTION

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

STANDARDS:

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

ECC-PM PAIN MANAGEMENT

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

STANDARDS:

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

ECC-PRO PROCEDURES

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

STANDARDS:

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

ECC-TE TESTS

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

STANDARDS:

1. Discuss the test(s) to be performed, i.e., x-ray.
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment. Discuss the risks of non-performance of the testing.

ECC-TX TREATMENT

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

STANDARDS:

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

ECZ—Eczema/Atopic Dermatitis

ECZ-C COMPLICATIONS

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

STANDARDS:

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

ECZ-DP DISEASE PROCESS

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

STANDARDS:

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

ECZ-FU FOLLOW-UP

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

STANDARDS:

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

ECZ-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

ECZ-M MEDICATIONS

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

STANDARDS:

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

ECZ-N NUTRITION

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

STANDARDS:

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

ECZ-P PREVENTION

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

STANDARDS:

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

ECZ-WC WOUND CARE

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

STANDARDS:

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

F

FP—Family Planning

FP-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

FP-DIA DIAPHRAGM

OUTCOME: The patient will understand the safe and effective use of a diaphragm.

STANDARDS:

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

FP-DPO DEPOT MEDROXYPROGESTERONE INJECTIONS

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

STANDARDS:

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

FP-EC EMERGENCY CONTRACEPTION (POST-COITAL)

OUTCOME: The patient/family will understand risks, benefits side effects, safety and effectiveness of Emergency Contraception.

STANDARDS:

1. Explain the methods of possible actions and effectiveness of Emergency Contraception.
2. Identify indications for use - a potential candidate is a reproductive-age woman who has had unprotected sexual intercourse within 72 hours of presenting herself for medical care, independent of the time of the menstrual cycle. Most common reasons for seeking the treatment are failure of a barrier method or failure to use any method.
3. Discuss the safety: there are no contraindications to EC pill due to the small overall hormone dose and the short duration of use. (Some studies excluded women from participating if they had an absolute contraindication to taking oral contraceptives). EC has no adverse affect on a fetus, if taken inadvertently. EC may be used during breastfeeding without effect on milk quantity or quality.
4. Review side effects, and management:
    a. Levonorgestal-only regimen: Nausea occurs in approximately 23 percent of women and vomiting occurs in about 6 percent, usually limited to the first three days after treatment.
    b. Combined estrogen-progestin (Yuzpe) regimen: Nausea and vomiting occur in about 43 and 16 percent, usually limited to the first three days after treatment.
    c. Both side effects can be minimized by the use of anti-emetic pre-treatment.
    d. A small number of women may experience irregular bleeding or spotting after taking ECs, this is not their menses. Most women will have their menstrual period within one week before or after the expected time.
    e. Breast tenderness can occur after EC treatment.

FP-FC FOAM AND CONDOMS

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

STANDARDS:

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

FP-FU FOLLOW-UP

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

STANDARDS:

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

FP-IC IMPLANT CONTRACEPTION

OUTCOME: The patient will understand the safe and effective use of implantable contraceptives.

STANDARDS:

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

FP-IUD INTRAUTERINE DEVICE

OUTCOME: The patient will understand the safe and effective use of the IUD.

STANDARDS:

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

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

FP-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

FP-MT METHODS

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

STANDARDS:

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

FP-N NUTRITION

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

STANDARDS:

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

FP-OC ORAL CONTRACEPTIVES

OUTCOME: The patient will understand the safe and effective use of oral contraceptives.

STANDARDS:

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

FP-ST STERILIZATION

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

STANDARDS:

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

F—Fever

F-C COMPLICATIONS

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

STANDARDS:

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

F-DP DISEASE PROCESS

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

STANDARDS:

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

F-EQ EQUIPMENT

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

STANDARDS:

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

F-FU FOLLOW-UP

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

STANDARDS:

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

F-HM HOME MANAGEMENT

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

STANDARDS:

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

F-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

F-M MEDICATIONS

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

STANDARDS:

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

F-TE TESTS

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

STANDARDS:

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

FF—Formula Feeding

FF-FS FORMULA FEEDING SKILLS

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

STANDARDS:

1. Explain the importance of selecting an age appropriate nipple that is comfortable to baby's mouth to feed formula at a rate that the baby can manage.
2. Emphasize that the infant should be held at a proper angle during feeding and that bottles should never be propped.
3. Emphasize that choking may result from the baby being left unattended with a bottle propped.
4. Explain that choice between plastic and glass bottles is up to parents. Glass is easy to clean dries quickly, and holds temperature better than plastic.
5. Explain the types of formulas available that are best suitable for baby's needs. Most infants require iron fortified formulas for brain growth.
6. Explain that some manufactures say their formula is "closer to breastmilk." This only means that the protein, fat, and other ingredients are more like that in breastmilk, not that the other formulas have all the unique nutritional and beneficial qualities of breastmilk.
7. Explain that fussing, spitting up, pulling off the nipple, or baby not wanting to eat during or after feeding may not necessarily be a problem with formula intolerance.
8. Explain that frequent stomachaches or vomiting, cough, runny nose and wheezing, skin itching and rash are examples of formula intolerance or allergy.
9. Explain that all commercial infant formulas are sufficient for the first year of life and that a change of formula is not necessary.
10. Explain that a formula fed baby does not need a fluoride supplement unless the water used to prepare formula has less than 0.3 ppm of fluoride.

FF-I INFORMATION

OUTCOME: The parents/family will have a basic understanding of the characteristics associated with formula feeding.

STANDARDS:

1. Explain that breastmilk has some characteristics that cannot be duplicated by even the most sophisticated formula; however, formula feeding is a good substitute.
2. Explain the higher risk of childhood obesity and type 2 diabetes for babies that are not breastfed.
3. Explain the higher risk of diarrhea, ear infections, constipation, dental carries, and lung infections for babies that are not breastfed.
4. Explain the higher risk of post partum hemorrhage and breast/ovarian cancer for mothers that do not breast-feed.
5. Explain that an infant under 1 year of age may be harmed by feeding goat's or cow's milk.
6. Emphasize that nothing should be fed to an infant from a bottle except breastmilk or formula unless advised by a health care professional.
7. Explain resources, such as WIC, for formula feeding and types.

FF-L PATIENT INFORMATION LITERATURE

OUTCOME: The parent(s) and family will receive written information about formula feeding.

STANDARDS:

1. Provide the parent(s) and family with written information about formula feeding.
2. Discuss the content of the patient information literature with the parent(s) and family.

FF-ME MATERNAL ENGORGEMENT

OUTCOME: Parents/family will understand how to successfully transition through breast engorgement in postpartum period.

STANDARDS:

1. Explain that stimulation to breast, such as pumping or suckling will prolong engorgement beyond 48 hours.
2. Encourage mother to use breast binder or snug bra until swelling goes away.
3. Explain signs of breast infection, such as sudden fever/malaise and need for pursuing medical evaluation.
4. Explain current treatments for engorgement.

FF-NJ NEONATAL JAUNDICE

OBJECTIVE: The family will understand the importance of monitoring for jaundice and the complications of unrecognized jaundice.

STANDARDS:

1. Explain that jaundice is the yellow color seen in the skin of many newborns which is caused by build up of bilirubin in the blood.
2. Explain that everyone's blood contains bilirubin, which is removed by the liver and that before birth, the mother's liver does this for the baby. Explain that many babies develop jaundice in the first few days after birth because it takes a few days for the baby's liver to get better at removing bilirubin.
3. Explain that the yellow skin color caused by bilirubin usually appears first in the face then moves to the chest, abdomen, arms and legs as the bilirubin level increases. Explain that the whites of the eyes may also be yellow.
4. Explain that mild jaundice is harmless but high levels of bilirubin may cause brain damage.
5. Explain that this brain damage can be prevented by treatment of the jaundice before the bilirubin level gets too high. Discuss that treatment options may include medical phototherapy or exchange transfusion.
6. Emphasize that parents should watch closely for jaundice and seek medical attention if jaundice is noticed.
7. Explain that medical personnel can check the level of bilirubin in the blood by blood tests or occasionally by a skin test.
8. Explain that all bilirubin levels must be interpreted in light of the infant's age and that term infants and older infants can tolerate higher levels of bilirubin than preterm infants and younger infants.
9. Explain that jaundice is more common in breastfed infants especially when the infant is not nursing well. Encourage nursing the infant a minimum of 8-12 times a day for the first week of life to increase milk production and keep bilirubin levels down. Emphasize that breastmilk is the ideal food for infants.

FF-S SAFETY OUTCOMES

OUTCOME: Parents/family will understand of preparing and storing formula.

STANDARDS:

1. Emphasize that the infant should be held at a proper angle during feeding and that bottles should never be propped.
2. Emphasize that choking may result from the baby being left unattended with a bottle propped.
3. Explain that bottle liners must be discarded after each use.
4. Explain that babies during the first three months of age have low resistance to bacteria and boiling water for 5 minutes before mixing formula may be necessary if the purity of water is in question. This also applies to purified or distilled water. **Refer to PB-TX**.
5. Explain that boiling bottles and nipples for 5 minutes, washing with hot, soapy water, and/or using a dishwasher before use is also recommended.
6. Explain that following manufactures instructions for mixing formula is extremely important and also using recommended measuring cups and spoons.
7. Explain that bottles should be prepared one at a time or in small batches, label, cover, refrigerate, and use within 48 hours. Discard any unused formula after each feeding and then wash the bottle immediately.
8. Explain that warming a formula bottle is best done under running tap water. Do not use a microwave oven to warm formula bottles.
9. Explain that bottle nipples should be discarded when they are old, soft, cracked, or discolored.

FF-SF INTRODUCTION TO SOLID FOODS

OUTCOME: The parent/family will understand the appropriate ages to introduce various solid foods. (teach any or all of the following as appropriate to this infant/family)

STANDARDS:

1. Explain that infants should not routinely be fed foods other than breastmilk or formula prior to 4 months of age except under the advice of a healthcare provider.
2. Emphasize that, for some time after the introduction of solid foods, breastmilk/formula will still be the infant's primary source of nutrition.
3. Emphasize that foods should never be given from a bottle or infant feeder and must always be fed from a spoon.
4. Explain that infants may be fed cereal mixed with breastmilk or formula not sooner than 4 months of age. Rice cereal is generally the preferred first solid food. It is normal for an infant to take very small amounts of solid foods for several months. Discard any uneaten food after each meal.
5. Emphasize the need to wait 3-5 days between the addition of new foods to watch for adverse events from the foods.
6. Explain that pureed/or finely mashed vegetables and fruits should be started no earlier than 6 months of age.
7. Explain that some foods such as peanut butter, chocolate, eggs, strawberries, cow or goat milk and citrus should not be fed until the infant is one year of age due to the highly allergenic nature of these foods. Explain that honey and syrups may contain botulism toxin and should not be fed before one year of age.
8. Explain that infants 14-16 moths of age will have a decreased appetite and will become more picky eaters.
9. Emphasize that some foods are easy to choke on and should be avoided until 4 years of age, i.e., nuts, hard candies, gum, carrot sticks, meat on a bone, grapes, popcorn, hot dogs, unpeeled apples, slices of orange.
10. Discuss the importance of offering foods at the appropriate ages but do not insist that infants eat foods when they are not hungry:
    a. Baby knows how much to eat
    b. It is important to go along with the baby when they feel they have finished eating
    c. Some days babies eat a lot other days not as much
    d. No two babies eat the same
11. Explain how to assess readiness, an infant:
    a. who exhibits tongue thrusting is not ready to eat solids.

b. will give you cues to readiness when they open their mouths when they see something coming

c. will close lips over a spoon

d. will keep food in their mouth instead of spitting it out

e. will sit up alone without support

12. Explain that the body of knowledge regarding infant feedings has changed dramatically and advice from family/friends may no longer be appropriate; talk to your healthcare provider.

FRST—Frostbite

FRST-C COMPLICATIONS

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

STANDARDS:

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

FRST-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

FRST-DP DISEASE PROCESS

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

STANDARDS:

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

FRST-FU FOLLOW-UP

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

STANDARDS:

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

FRST-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

FRST-M MEDICATIONS

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

STANDARDS:

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

FRST-N NUTRITION

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

STANDARDS:

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

FRST-P PREVENTION

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

STANDARDS:

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

FRST-PM PAIN MANAGEMENT

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

STANDARDS:

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

FRST-TX TREATMENT

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

STANDARDS:

1. Discuss the goal of treatment with the patient; prevention of further exposure to affected area(s), and management and prevention of complications.
2. Emphasize the need to have frostbite injuries rewarmed under medical supervision.
3. Explain that the patient needs to get to a warm place where he/she can stay warm after thawing. Refreezing can cause more severe tissue damage.
4. Review proper thawing process:
    a. Use warm-to-the touch water 100˚ F (38˚ C.) For 30-45 minutes until a good color (flush) has returned to the entire area. Emphasize that this process may be painful, especially the final few minutes.
    b. Leave the blisters intact. Cover with a sterile or clean covering if protection is needed to prevent rupturing of blisters.
    c. Keep the affected part(s) as clean as possible to reduce the risk of infection.
    d. Keep the affected area elevated above the level of the heart.
5. Emphasize the importance of having a current tetanus booster (within5-10 years).
6. Review treatment modalities that are not deemed appropriate methods to treat frostbite:
    a. Don’t use dry heat (sunlamp, radiator, heating pad) to thaw the injured area.
    b. Don’t thaw the injury in melted ice.
    c. Don’t rub the area with snow.
    d. Don’t use alcohol, nicotine or other drugs that may affect blood flow.

FRST-WC WOUND CARE

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

STANDARDS:

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

G

GE—Gastroenteritis

GE-C COMPLICATIONS

OUTCOME: The patient/family will understand the possible complications of gastroenteritis and which patients are at high risk for complications.

STANDARDS:

1. Discuss the common or serious complications of gastroenteritis, such as:
   a. dehydration
   b. electrolyte imbalance
   c. need for hospitalization.
2. Explain that people with concurrent or chronic illness, the elderly, the very young, or people who have prolonged episodes of gastroenteritis are at higher risk for complications.

GE-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

GE-DP DISEASE PROCESS

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

STANDARDS:

1. Explain that gastroenteritis is usually caused by a viral infection and will go away on its own.
2. Review the signs and symptoms of gastroenteritis such as:
   a. colicky abdominal pain
   b. fever which may be low grade or higher
   c. diarrhea
   d. nausea and/or vomiting.
3. Discuss the potential for dehydration and signs of dehydration:
   a. dry sticky mouth
   b. no tears when crying
   c. no urine output for 8 hours or more
   d. sunken fontanelle (in an infant)
   e. sunken appearing eyes
   f. others as appropriate.
4. Explain the need to seek immediate medical care if dehydration is suspected.

GE-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the individual's responsibility in the management of gastroenteritis.
2. Review the treatment plan with the patient, emphasizing the importance of checking for signs of dehydration.
3. Discuss the procedure for obtaining follow-up appointments as appropriate.

GE-HM HOME MANAGEMENT

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

STANDARDS:

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

GE-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

GE-M MEDICATIONS

OUTCOME: The patient /family will understand the limited role medications play in the management of gastroenteritis.

STANDARDS:

1. Explain that in most cases of gastroenteritis no medication is needed.
2. If medication is prescribed for nausea relief or diarrhea control, provide a brief description of how the medication works, what the common or problematic side-effects.
3. Explain that many medications prescribed for nausea or diarrhea may cause drowsiness and the patient should avoid activities such as driving or operating heavy machinery while using these medications.
4. Explain the importance of proper hydration even in the face of drowsiness.

GE-N NUTRITION

OUTCOME: The patient will understand ways to treat gastroenteritis by nutritional therapy.

STANDARDS:

1. Explain that in gastroenteritis the gastrointestinal tract is not working properly.
2. Explain that gastrointestinal rest is essential to quick recovery from gastroenteritis.
3. Explain that water and many other clear liquids are rapidly absorbed across the stomach wall and do not require that the gastrointestinal tract be working properly. (Oral electrolyte solutions are excellent clear fluids for all who will take them.)
4. Discourage the use of juices as many of them will make the diarrhea worse.
5. Discourage the use of caffeinated beverages as they are dehydrating.
6. Explain that clear liquids taken in small amounts and frequently will often result in resolution of the vomiting, i.e., 1 teaspoonful to 1 tablespoonful every 5-10 minutes.
7. Explain that it is usually appropriate to go to a high starch/low fat diet gradually.

GE-PM PAIN MANAGEMENT

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

STANDARDS:

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

GE-TE TESTS

OUTCOME: The patient /family will understand the conditions under which testing is necessary and the specific test(s) to be preformed, technique for collecting samples and the expected benefit of testing and any associated risks. The patient/family will also understand alternatives to testing and the potential or risks associated with the alternatives, i.e., risk of non-treatment.

STANDARDS:

1. Explain that tests may be necessary for prolonged gastroenteritis or gastroenteritis accompanied by diarrhea with blood or mucus. Discuss the procedure for collecting the sample, the benefit expected and any associated risks.
2. Explain the alternatives to the proposed test(s) and the risk/benefits ratio of the testing and alternatives including the risk of non-treatment.

GE-TX TREATMENT

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

STANDARDS:

1. Explain that the major treatment for viral gastroenteritis is dietary modification.
2. Explain that if the gastroenteritis is caused by a bacterium, antibiotics may be prescribed.
3. Explain that if the patient fails attempts at oral rehydration, I.V. rehydration is frequently necessary.

GER—Gastroesophageal Reflux Disease

GER-DP DISEASE PROCESS

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

STANDARDS:

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

GER-FU FOLLOW-UP

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

STANDARDS:

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

GER-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

GER-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

GER-M MEDICATIONS

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

STANDARDS:

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

GER-N NUTRITION

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

STANDARDS:

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

GER-PM PAIN MANAGEMENT

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

STANDARDS:

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

GER-SM STRESS MANAGEMENT

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

STANDARDS:

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

GER-TE TESTS

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

STANDARDS:

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

GER-TX TREATMENT

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

STANDARDS:

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

GENE—Genetic Disorders

GENE-BH BEHAVIORAL AND SOCIAL HEALTH

OUTCOME: The patient/family will understanding the behavioral and social aspects of this genetic disorder.

STANDARDS:

1. Discuss that caring for special needs individuals may result in a variety of emotions and may require medical intervention or counseling.
2. Refer to community resources as appropriate.
3. Refer to a social worker for assistance with special programs.

GENE-C COMPLICATIONS

OUTCOME: The patient/family will understand complications which are more common with this genetic disorder than in the general population.

STANDARDS:

1. Discuss complications more common in persons with this genetic disorder (i.e., hypothyroidism, alantoaxial instability with Down syndrome.)

GENE-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.

GENE-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.

GENE-I INFORMATION

OUTCOME: The parents/family will understand the genetic disorder that has been diagnosed or is being considered.

STANDARDS:

1. Discuss the symptoms of the genetic disorder
2. Discuss the inheritance pattern of the genetic disorder, if known.
3. Explain implications for future pregnancies, as appropriate.
4. Refer to pre-pregnancy and/or genetic counseling, as available or appropriate.

GENE-L PATIENT INFORMATION LITERATURE

OUTCOME: The parents/family will receive written information about the genetic disorder.

STANDARDS:

1. Provide the parents/family with written information about the genetic disorder.
2. Discuss the content of the patient information literature with the parent(s)/family.

GENE- LA LIFESTYLE ADAPTATION

OUTCOME: The patient/family will understand lifestyle adaptations necessary to care for a person with a genetic disorder.

STANDARDS:

1. Discuss lifestyle adaptations specific to this genetic disorder.
2. Discuss the availability of special programs and explain that parent must be advocates for their child with special needs (i.e., Birth to 3, Head Start, special school programs)
3. Refer to community services, resources, or support groups, as available.

GENE-N NUTRITION

OUTCOME: The patient/family will understand the special nutritional needs of persons with this genetic disorder.

STANDARDS:

1. Discuss nutritional needs of persons with this genetic disorder (i.e., some genetic disorders cause failure to thrive while others may cause obesity).
2. Refer to a registered dietitian.

GENE-P PREVENTION

OUTCOME: The parents/family will understand any preventive measures for future occurrences of a genetic disorder, as appropriate.

STANDARDS

1. Discuss factors that influence the occurrence of genetic disorders (i.e., older maternal age predisposes to Down syndrome).
2. Discuss genetic counseling options especially with families with previous occurrences of genetic disorders.

GENE-PA PARENTING

OUTCOME: The parent will understand the special parenting challenges of this genetic disorder.

STANDARDS:

1. Discuss that many genetic disorders render the patient incapable of independent life and that the parents will need to plan for long term care of the patient.
    a. Discuss that many of these patients will require parenting well beyond 18 years of life.
    b. Discuss that the parents should plan early for an alternative care plan in the event of death of the parents (i.e., designating a guardian, setting up trust funds)
    c. Discuss the need for consistent parenting especially in children with special needs.
    d. Discuss the need for respite care (alternative caregivers) to allow for time for the parent to have time for him/herself.

GENE-PT PHYSICAL THERAPY

OUTCOME: The patient/family will understand the role that physical/occupational/speech therapies play in the functional ability of persons with genetic disorders.

STANDARDS:

1. Discuss physical/occupational/speech therapies as appropriate to this patient.
2. Refer as appropriate.

GENE-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand safety issues specific to this genetic disorder.

STANDARDS:

1. Discuss that some genetic disorders result in lower IQs and that this often makes the patient more vulnerable to many personal safety hazards including sexual abuse/assault.
2. Discuss safety and injury prevention issues as related to this genetic disorder.

GENE-SM STRESS MANAGEMENT

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

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

GENE- 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. Test may be performed to rule out other disease processes.
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.

H

HEAT—Heatstroke

HEAT-C COMPLICATIONS

OUTCOME: The patient and/or family will understand the consequences of heat stroke and the complications associated with heatstroke.

STANDARDS:

1. Explain that the body tissues and cells breakdown (denaturization of enzymes, destabilization of cells and breakdown of metabolic pathways) when the body's temperature increases above 105.8˚ F (41˚ C).
2. Discuss the complications of multisystem failure and the risks of morbidity and mortality that can occur as a result of heatstroke.
3. Discuss the possibility of circulatory collapse, which may precede permanent brain damage or death.

HEAT-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

HEAT-DP DISEASE PROCESS

OUTCOME: The patient and/or family will understand how heat stroke occurs and the signs and symptoms of heatstroke.

STANDARDS:

1. Discuss the two different categories of heatstroke: exertional and non-exertional.
2. Discuss signs and symptoms of heatstroke with the patient:
   a. headache
   b. vertigo
   c. fatigue
   d. decreased sweating
   e. skin warm to touch
   f. flushing
   g. increased heart rate
   h. increased respiratory rate.
3. Discuss the pathophysiology of heat stoke: inadequacy or failure of the heat loss mechanism.
4. Discuss warning signs of heat stroke: headache, weakness, and sudden loss of consciousness.
5. Discuss with the patient that heatstroke is an emergency.
6. Explain that some disease states or conditions may predispose to heat stroke, i.e., diabetes, anhydrosis or previous episodes of heat stroke.
7. Explain that environmental conditions such as high humidity, extremely high temperatures can predispose to heat stroke.
8. Discuss that tight clothing or spandex or rubber clothing can predispose to heat stroke.

HEAT-EX EXERCISE

OUTCOME: The patient and/or family will understand how heatstroke can be influenced by exercise.

STANDARDS:

1. Discuss with patient/family how exercising in a warm environment, excessive exercising and prolonged exercise and exertion can lead to heatstroke.
2. Discuss the importance of frequent hydration and rest when exercising in a warm environment.

HEAT-FU FOLLOW-UP

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

STANDARDS:

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

HEAT-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

HEAT-M MEDICATIONS

OUTCOME: The patient/family will understand the use of medications in the emergency room to manage heatstroke.

STANDARDS:

1. Discuss with the patient that pharmacological therapy may not be required.
2. Discuss with the patient that signs/symptoms such as dysrhythmia and shivering may occur as a complication of heatstroke and may require medication therapy.
3. Discuss with the patient that once they leave the hospital they may require medications that will treat the complications that have occurred from the heatstroke.
4. Discuss with the patient the importance of following the instructions in regards to their medications.
5. Discuss the common and important side effects and drug interactions of the medications prescribed.

HEAT-N NUTRITION

OUTCOME: The patient/family will understand the importance of adequate hydration and that water is the beverage of choice.

STANDARDS:

1. Explain that water is the beverage that best hydrates the body.
2. Discuss that caffeinated beverages and alcohol are especially dangerous and may predispose to dehydration and heat stroke.

HEAT-P PREVENTION

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

STANDARDS:

1. Discuss that it is easier to prevent heat stroke than to treat it.
2. Discuss with the patient/family that the majority of heat stroke cases are preventable by avoiding extremely hot/humid environments, inadequately ventilated spaces, inadequate fluid intake and heavy clothing in warm conditions.
3. Discuss with the patient/family ways to prevent heatstroke when heat exposure cannot be avoided; reducing or eliminating strenuous activities, staying adequately hydrated, frequently taking showers, wearing light weight clothing and avoiding direct sunlight.
4. Discuss that up to a liter an hour may be required to prevent dehydration and predispose to heat stroke.
5. Discuss with the patient the most likely time of year to develop heatstroke: summer.
6. Discuss with patient the risk factors such as increased age, debility, low fluid intake, excessive exercise, alcohol and drug use, chronic disease, living conditions with no air-conditioning, travel to warmer climates, and prolonged outdoor activities.

HEAT-TE TESTS

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

STANDARDS:

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

HEAT-TX TREATMENT

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

STANDARDS:

1. Discuss the importance of seeking emergency care if heatstroke is suspected.
2. Discuss the importance of slowly decreasing the temperature of the person.
3. Discuss the management of heatstroke in the emergency department; protection of airway, intravenous administration of fluids, monitoring of temperature, decreasing of temperature, and monitoring of cardiorespiratory status.
4. Discuss the goal of treatment with the patient; prevention of further heat loss, decrease in the core body temperature, and management and prevention of complications.
5. Discuss with the patient/family the importance of seeking emergency help as soon as possible in the incidence of a heatstroke.
6. Discuss the probability that the person experiencing a heatstroke may be admitted to an intensive care unit for extensive monitoring.

HPTH—Hypothermia

HPTH-C COMPLICATIONS

OUTCOME: The patient/Family will understand common or serious complications of hypothermia.

STANDARDS:

1. Explain that complications depend on how low and how long the body temperature falls.
2. Explain that the lower the core body temperature, the greater the chance of complications and permanent damage.
3. Discuss common and important complications of hypothermia, i.e., arrhythmias, dehydration, hyperkalemia, hyperglycemia, hypoglycemia, altered arterial blood gasses, infection, gangrene, amputation, coma, and frostbite. **Refer to FRST**.
4. Emphasize to seek early medical intervention.

HPTH-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

HPTH-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of hypothermia.

STANDARDS:

1. Explain that body temperature regulation is achieved through precise balancing of heat production, heat conservation, and heat loss.
2. Explain the normal body temperature range is considered to be 36.2° to 37.7°C (96.2° to 99.4° F) but that all parts of the body do not have the same temperature.
3. Explain that a drop in the body's core temperature to 95° F or below is the definition of hypothermia.
4. Discuss that hypothermia usually comes on gradually and people aren't aware they need medical attention.
5. Discuss that common behaviors/signs may be a result of changes in motor coordination and levels of consciousness caused by hypothermia. Some common signs are:
    a. shivering, which is your body's attempt to generate heat through muscle activity
    b. "umbles" — stumbles, mumbles, fumbles and grumbles.
    c. Slurred speech
    d. Abnormally slow rate of breathing
    e. Cold, pale skin
    f. Fatigue, lethargy, or apathy
6. Explain the extremities are generally cooler than the trunk and the body core is generally warmer than the skin surface.
7. Briefly describe hypothermia causes vasoconstriction, alterations in microcirculation, coagulation, and ischemic tissue damage.
8. Explain that environmental conditions, inadequate clothing, and some disease states or conditions may predispose to hypothermia.

HPTH -EQ EQUIPMENT

OUTCOME: The patient/family will understand the indication for the use of equipment.

STANDARDS:

1. Discuss the indications for and benefits of prescribed equipment.
2. Discuss types and features of medical equipment as appropriate.
3. Discuss signs of equipment malfunction and the proper action to take in case of malfunction.

HPTH -FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the prevention of complications.

STANDARDS:

1. Discuss the importance of keeping follow-up appointments.
2. Discuss the procedure for obtaining follow-up appointments.

HPTH -L PATIENT INFORMATION LITERATURE

OUTCOME: The parent(s) and family will receive written information about hypothermia and important preventative measures.

STANDARDS:

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

HPTH -M MEDICATIONS

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

STANDARDS:

1. Discuss with the patient that complications of hypothermia may require medication therapy.
2. Discuss the importance of taking medication as prescribed.
3. Discuss the common and important side effects and drug interactions of the medications prescribed.

HPTH -N NUTRITION

OUTCOME: The patient/family will understand the importance of adequate nutrition to promote healing.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between making healthy food choices and the healing process.
3. Refer to registered dietician.

HPTH -P PREVENTION

OUTCOME: The patient/family will understand ways to decrease the risk of hypothermia.

STANDARDS

1. Explain that it is easier to prevent hypothermia than to treat it.
2. Discuss risk factors to decrease the risk of hypothermia:
    a. poor or inadequate insulation from the cold or wind
    b. impaired circulation from tight clothing or shoes
    c. fatigue
    d. altitude
    e. wind
    f. immersion
    g. injuries
    h. circulatory disease
    i. poor nutrition
    j. dehydration
    k. alcohol or drug use
    l. tobacco products
    m. extremes of age
3. Discuss ways to decrease risk of hypothermia such as:
    a. Using appropriate layered clothing
    b. avoiding overexertion while outdoors in cold weather
    c. stay dry as much as possible
    d. keep an emergency supply kit in the car which may include blankets, food, matches, candles

HPTH -PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that pain management may be multifaceted. **Refer to PM.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control symptoms of pain.
4. Discuss non-pharmacologic measures that may be helpful with pain control.

HPTH-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in recovery from hypothermia.

STANDARDS:

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

HPTH -TE TESTS

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

STANDARDS:

1. Explain the tests ordered (X-Ray, EKG, urine, blood, ABG's).
2. Explain any necessary preparation prior to tests(s).
3. Explain the indications, risks and benefits of the test(s).
4. Explain the meaning of test results in relation to what "normal" results are.
5. Explain the test as it relates to planning the course of treatment.

HPTH -TX TREATMENT

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

STANDARDS:

1. Discuss the importance of seeking emergency medical care if hypothermia is suspected.
2. Explain if medical attention is not readily available then move the person out of the cold, remove wet clothing, insulate the person's body from the cold ground, monitor breathing, share body heat, and if conscious provide warm nonalcoholic beverages.
3. Discuss what **not** to do if hypothermia is suspected:
   a. Don't apply direct heat
   b. Don't massage or rub the person
   c. Don't provide alcoholic beverages
4. Discuss the importance of slowly increasing the temperature of the person and getting the person into dry clothes when applicable.
5. Discuss the management of hypothermia (i.e., monitoring of vital signs, warming blankets, warm IV fluids, extracorporeal circulation)

LTH—Hypothyroidism

LTH-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the anatomy and physiology of the pituitary-thyroid axis.

STANDARDS:

1. Explain the normal location, function, and feedback mechanism of the pituitary-thyroid axis (heart rate, muscle strength, bowel function, fat metabolism, energy level, hair growth, and mood).
2. Discuss the changes to the thyroid gland and the body's metabolic state as a result of hypothyroidism.
3. Discuss the impact of these changes on the patient's health and well-being.

LTH-C COMPLICATIONS

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

STANDARDS:

1. Discuss the significant complications associated with hypothyroidism (depression, excessive weight gain, high blood pressure, high cholesterol levels).
2. Discuss that full participation with the treatment regimen may prevent most or all significant complications.
3. Discuss common or significant complications which may result from treatment, i.e., jitteriness, heart racing, headaches. Consistently taking medications at the appropriate dose will minimize these complications.

LTH-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology of hypothyroidism.

STANDARDS:

1. Explain that hypothyroidism occurs when the amount of thyroid hormone in the blood is too low. It affects almost 5% of the population. It is more common in women and in elderly persons.
2. Explain that hypothyroidism leads to an overall decrease in a person's metabolism, which can cause a number of problems.
3. Review the patient-specific cause and expected course of hypothyroidism. In most cases hypothyroidism is a permanent condition that requires life-long treatment with natural thyroid supplement.
4. Review the symptoms of hypothyroidism, which include feelings of:
    a. fatigue
    b. lack of motivation
    c. sleepiness
    d. weight gain
    e. feelings of being constantly cold
    f. constipation
    g. dry skin
    h. hair loss
    i. muscle cramps and muscle weakness
    j. high blood pressure and high cholesterol levels
    k. depression
    l. slowed speech
    m. poor memory
    n. feelings of "being in a fog."

LTH-EX EXERCISE

OUTCOME: The patient/family will understand the relationship between physical activity and hypothyroidism and develop a plan to achieve an appropriate level of activity.

STANDARDS:

1. Explain the normal benefits of a regular exercise program to health and well-being.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.
7. Discuss that in hypothyroidism, severe muscle weakness may occur and exercise tolerance is impaired. Explain that exercise is important not only for weight control, but also to reestablish muscle tone and fitness. In general, intense aerobic exercise should only be attempted after thyroid hormone levels have returned to normal. However, the patient can begin walking and modest weight-bearing exercise as treatment is initiated.

LTH-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the individual's responsibility in the management of hypothyroidism.
2. Review the treatment plan with the patient, emphasizing the need for keeping appointments, fully participating with medication therapy, returning for appropriate follow-up, lab tests, and appointments.
3. Review the symptoms, which should be reported and evaluated (both symptoms of hyperthyroidism and hypothyroidism).
4. Assist the patient in making follow-up appointments as appropriate.

LTH-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

LTH-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

1. Emphasize that weight gain, high blood pressure, and high cholesterol levels are associated with hypothyroidism.
2. Explain that although most hypothyroid individuals will lose weight after they begin taking a thyroid supplement, significant weight loss will usually require attention to healthy eating habits and exercise. Individuals should avoid setting unrealistic goals.

LTH-M MEDICATIONS

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

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication.
2. Emphasize the importance of maintaining full participation in the medication regimen and monitoring schedule.
3. Explain the signs and symptoms of too much or too little medication.
4. Explain the implications that medications have on current or potential pregnancy.
5. Discuss drug/drug and drug/food interactions as appropriate.
6. Discuss that some medications may have an adverse effect on the disease state, i.e., amiodarone, iodine.

LTH-N NUTRITION

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

STANDARDS:

1. Review normal nutritional needs for optimal health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss the need for the correct combination of nutrients and vitamins, as well as the need for a low-fat diet without excessive calories.
4. Explain that the following foods must be limited: cabbage, brussel sprouts, kale, cauliflower, asparagus, broccoli, soy beans, lettuce, peas, spinach, turnip greens and watercress as these foods may increase the risk of developing a goiter.
5. Explain that the long term use of soy protein products may be contraindicated.
6. Encourage the use of iodized salt if indicated.
7. Refer to registered dietician.

LTH-SCR SCREENING

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

STANDARDS

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

LTH-TE TESTS

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

STANDARDS:

1. Explain the test ordered, i.e., TSH, T3, T4, nuclear scan, ultrasound, blood counts.
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment. Discuss the risks/benefits of non-testing.

I

IM—Immunizations

IM-DEF DEFICIENCY

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

STANDARDS:

1. Identify reasons for deficiency and provide education as indicated.
2. Explain that deficiency of immunization(s) may cause serious health problems.
3. Discuss diseases that have been eradicated due to immunizations.
4. Discuss the patient's particular immunization deficiency.
5. Review complications that could occur if infection develops.

IM-FU FOLLOW-UP

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

STANDARDS:

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

IM-I IMMUNIZATION INFORMATION

OUTCOME: Patient/family will understand the indication for and benefit of immunization, common and important side effects of vaccination, and post immunization care.

STANDARDS:

1. Explain the indication for immunization including the disease which is to be prevented by immunization.
2. Explain the contraindications of administering the vaccine.
3. Discuss appropriate vaccine sites.
4. Explain the important and common side effects of immunizations to be administered.
5. Explain post-immunization care including dose of antipyretics if needed and what to do if serious side effects are observed.
6. Explain how family members can assist with comforting immunized persons during and after vaccine administration, as culturally appropriate.

IM-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

IM-P PREVENTION

OUTCOME: The patient/family will understand communicability and measures to control vaccine preventable disease for children and adults.

STANDARDS:

1. Explain that vaccines are available against certain infections or diseases.
2. Explain that certain infections can be eliminated or avoided through immunizations.
3. Provide information on types of vaccines available for children and adults.
4. Explain that good hand hygiene, use of tissues and waste receptacles and avoiding touching eyes, nose, and mouth are also important measures in the control of some disease transmission.

IM-SCH SCHEDULE

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

STANDARDS:

1. Explain that some vaccines are prescribed to be given in series, within certain time frames and may not be counted if given too early and may need to be repeated.
2. Explain that some vaccines are required by law.
3. Provide schedules on types of vaccines for children and adults.

IGT—Impaired Glucose Tolerance

Refer to PDM—Prediabetes.

IMP—Impetigo

IMP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the disease process, transmission and causative agent of impetigo.

STANDARDS:

1. Explain that impetigo may be caused by the streptococcus or staphylococcus germs.
2. Explain that impetigo is a skin infection that can spread from one place to another on the body.
3. Explain that impetigo can also spread from person to person.
4. Explain that impetigo may follow superficial trauma with a break in the skin; or the infection may be secondary to pediculosis, scabies, fungal infections, or insect bites.
5. Explain that itching is common and scratching may spread the infection.
6. Describe what to look for:
    a. lesions with a red base and a honey or golden-colored crust or scab
    b. may occur anywhere on the skin, (arms, legs and face are the most susceptible.)
    c. lesions may be itchy
    d. lesions may produce pus.

IMP-FU FOLLOW-UP

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

STANDARDS:

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

IMP-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

IMP-M MEDICATIONS

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

STANDARDS:

1. Review the proper use, benefits and common side effects of prescribed medications.
2. Explain the importance of completing the full course of antibiotic therapy to prevent antibiotic resistance and to facilitate complete recovery.
3. Explain the importance of adhering to the medication schedule.

IMP-P PREVENTION

OUTCOME: The patient/family will better understand how to prevent skin infections.

STANDARDS:

1. Instruct the patient/family to wash with soap and water every day.
2. Discuss the importance of hand washing in infection control in relation to child care and toilet use. Stress the importance of washing the hands whenever they are dirty.
3. Advise to keep the fingernails cut and clean.
4. Advise to take care of cuts, scratches, and scrapes. Instruct to wash with soap and water.
5. Discourage sharing clothes, towels, toys, dishes, etc. with a person who has impetigo.
6. Explain that certain infections can be dependent upon hygiene, social and/or environmental conditions. **Refer to WL-HY**.
7. Encourage parents/caregivers to wash all toys with soap and water.

IMP-TX TREATMENT

OUTCOME: The patient/family will understand the treatment plan.

STANDARDS:

1. Instruct the patient/family to keep the lesions clean and dry. Washing with an antibacterial soap is beneficial.
2. Instruct to use antibiotic ointment each time after washing, or as ordered.
3. Instruct the patient/family to change and wash clothes, bedding, towels and toys.
4. Discourage scratching sores. Inform the patient/family this can make them worse and cause spreading of the infection.
5. Instruct the patient/family to return to the clinic in 3 to 4 days or as prescribed by physician if the sores are not getting better.
6. Discuss the signs of worsening condition, i.e., increasing redness, soreness, high fever.

FLU—Influenza

FLU-C COMPLICATIONS

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

STANDARDS:

1. Discuss that one of the most common complications of the flu is pneumonia and may lead to hospitalization.
2. Explain that the flu causes many deaths in the United States every year.
3. Discuss groups who are at higher risk for complications from the flu such as the elderly and infants. Also discuss that persons with chronic diseases such as pulmonary disease, cardiac disease, renal disease, cancer and diabetes are at higher risk for complications from the flu.
4. Discuss the importance of not giving aspirin or products containing aspirin to children (under 16 years of age) with the flu as it may induce a potentially fatal complication of the flu called Reye Syndrome.

FLU-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the basic pathophysiology of influenza infection.

STANDARDS:

1. Discuss that the flu is caused by an influenza virus and that antibiotics are not helpful in treating the flu.
2. Explain that the flu virus changes every year so that having had the flu in a previous year will not necessarily make one immune to flu this year.
3. Discuss that the most common symptoms of the flu are muscle aches, head ache, fever, malaise, non-productive cough, and fatigue.
4. Explain that the flu is spread from person to person by inhalation of small particle aerosols, by direct contact or by contact with objects that have recently been contaminated by secretions from someone who has the flu.

FLU-FU FOLLOW-UP

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

STANDARDS:

1. Discuss signs and symptoms that would indicate worsening of the disease and prompt a follow-up visit.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize the importance of keeping follow-up appointments.

FLU-IM IMMUNIZATION

OUTCOME: The patient/family will understand the role that immunization plays in preventing influenza. (Discuss the following as appropriate to this patient and situation.)

STANDARDS:

1. Discuss that the vaccine for the flu is formulated for the viruses that are predicted to be most prevalent this year.
2. Discuss that the currently available injected flu vaccines are killed virus vaccines and cannot cause the flu. (Please refer to current information on this year's flu vaccine.)
3. Discuss that there is a live attenuated intranasal vaccine available. This vaccine may protect individuals not only from the flu strains in the vaccine but also other flu strains. It may also decrease the incidence of colds and ear infections.
4. Discuss that persons who have a history of Guillain-Barre Syndrome, egg hypersensitivity or hypersensitivity to any flu vaccine component should probably not get the flu vaccine unless ordered by a physician.
5. Discuss that current injectable flu vaccines are not licensed for use in individuals under the age of 6 months and that the intranasal flu vaccine is licensed for use in individuals between the ages of 5-49 years.
6. Discuss that persons at high risk for complications from influenza are recommended to receive the flu vaccine every year.
7. Discuss the common and important complications of flu vaccine.

FLU-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

FLU-M MEDICATIONS

OUTCOME: The patient/family will understand the role of medications used to reduce flu symptoms and/or duration. (discuss the following as appropriate).

STANDARDS:

1. Discuss treatment of symptoms with OTC medications including decongestants, cough suppressants, antipyretics, analgesics, antihistamines.
2. If appropriate, discuss that aspirin should not be used in patients that are under 16 years of age due to risk of Reye's syndrome.
3. Discuss the use of antiviral treatment for influenza and that therapy must be started within 48 hours.
4. Review the proper use, benefits and common side effects of prescribed medications.
5. Explain the importance of completing the full course of antiviral therapy, as prescribed, to prevent antibiotic resistance and to facilitate complete recovery.
6. Explain the importance of adhering to the medication schedule.
7. Discuss that zinc, Echinacea and vitamin C over the counter products for viral infections have not proven to be effective.
8. Explain that antibiotics are not used for viral illnesses because they are not effective on viruses:
    a. Antibiotics used for viral infections can cause antibiotic resistance
    b. Antibiotics can also cause side effects, allergic reactions, and increased cost with no benefit to treating the viral illness.

FLU-N NUTRITION

OUTCOME: The patient/family will understand how nutrition may impact the management of influenza.

STANDARDS:

1. Explain that influenza causes increased fluid losses and that extra fluid intake is usually required.
2. Explain that chicken soup may actually be helpful because it provides extra fluid, potassium and sodium.
3. Explain that small frequent meals or sips of fluid may be better tolerated than larger meals.
4. Discuss that vomiting may be present:
    a. Liquids or food will be better tolerated if the stomach is allowed to "rest" for 30 minutes to one hour before attempts to consume other fluids or foods.
        i. Small frequent intake of fluids will be better tolerated.
        ii. 5 to 15 cc's of clear fluid every 5 to 10 minutes until 8 hours have passed without vomiting is one effective strategy.

FLU-P PREVENTION

OUTCOME: The patient/family will understand communicability and measures to prevent the flu.

STANDARDS:

1. Discuss that influenza is a vaccine preventable disease. **Refer to FLU-IM.**
2. Emphasize the importance of receiving influenza vaccine every year as the virus that causes the flu changes every year.
3. Discuss that careful hand washing can help to prevent the spread of influenza.
4. Discuss that avoiding crowded places can decrease chances of getting influenza.
5. Discuss the importance of covering one's mouth and nose when coughing or sneezing and proper disposal of tissues.
6. Explain that influenza can be spread by fomites (i.e., contaminated objects such as telephone receivers), and that common use of disinfectant cleaners may reduce this spread.

INJ—Injuries

INJ-CC CAST CARE

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

STANDARDS:

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

INJ-EQ EQUIPMENT

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

STANDARDS:

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

INJ-EX EXERCISE

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

STANDARDS:

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

INJ-FU FOLLOW-UP

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

STANDARDS:

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

INJ-HM HOME MANAGEMENT

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

STANDARDS:

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

INJ-I INFORMATION

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

STANDARDS:

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

INJ-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

INJ-M MEDICATION

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

STANDARDS:

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

INJ-P PREVENTION

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

STANDARDS:

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

INJ-PM PAIN MANAGEMENT

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

STANDARDS:

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

INJ-TE TESTS

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

STANDARDS:

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

INJ-WC WOUND CARE

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

STANDARDS:

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

L

LAB—Laboratory

LAB-DRAW PHLEBOTOMY

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

STANDARDS:

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

LAB-FU FOLLOW-UP

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

STANDARDS:

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

LAB-L LITERATURE

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

STANDARDS:

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

LAB-S SAFETY

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

STANDARDS:

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

LAB-TE TESTS

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

STANDARDS:

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

PB—Lead Exposure/Lead Toxicity

PB-C COMPLICATIONS

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

STANDARDS:

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

PB-DP DISEASE PROCESS

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

STANDARDS:

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

PB-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of regular follow-up care and routine screening for high risk populations.
2. Refer to PHN or community resources as appropriate.

PB-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

PB-N NUTRITION

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

STANDARDS:

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

PB-P PREVENTION

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

STANDARDS:

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

PB-SCR SCREENING

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

STANDARDS:

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

PB-TE TESTS

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

STANDARDS:

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

PB-TX TREATMENTS

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

STANDARDS:

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

M

MSX—Metabolic Syndrome

MSX-C COMPLICATIONS

OUTCOME: The patient will understand the complications associated with metabolic syndrome.

STANDARDS:

1. Explain that metabolic syndrome is a precursor to cardiovascular disease and diabetes.
2. Explain that arteriosclerosis and atherosclerosis impede blood flow through the circulatory system.
3. Explain that heart attacks may result from the heart having to work harder to pump blood through congested and hardened arteries.
4. Explain that good control of blood sugar can reverse or prevent progression of pre-diabetes.
5. Explain that strokes may result due to injured blood vessels in the neck or brain.
6. Explain that blindness may result from injured blood vessels in the eye.
7. Explain that leg pain may result due to injured blood vessels in the legs.

MSX-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

MSX-DP DISEASE PROCESS

OUTCOME: The patient will have a basic understanding of the pathophysiology of the metabolic syndrome.

STANDARDS

1. Explain that metabolic syndrome is a combination of dyslipidemia, hypertension and pre-diabetes (insulin resistance).
2. Review the risk factors and causative factors of dyslipidemia, hypertension and pre-diabetes.
3. .Discuss HDL, non-HDL, LDL and triglycerides. Define normal ranges.
4. Explain the difference between systolic and diastolic pressure. Define normal ranges.
5. Discuss the role of insulin resistance**.** Define normal ranges.

MSX –EQ EQUIPMENT

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

STANDARDS:

1. Provide the patient with information on the use of specific home blood pressure monitors and pedometers.
2. Discuss the use of blood pressure monitoring equipment in public places, i.e., such as stores.
3. Discuss correct way to record blood pressure and pedometer activity in a logbook and bring to clinic visits.
4. Discuss when to contact a healthcare provider for a blood pressure value which is outside the patient's personal guidelines.
5. Discuss the proper use and care of medical equipment.
6. Discuss signs of equipment malfunction and proper action in case of malfunction.

MSX-EX EXERCISE

OUTCOMES: The patient will understand the relationship of exercise to normal lipids, blood pressure and blood sugar. The patient will develop a physical activity plan.

STANDARDS:

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

MSX-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the patient's responsibility in developing and following a treatment plan and keeping follow-up appointments.
2. Discuss the procedure for making appointments.
3. Discuss any necessary preparation for lab test(s).

MSX-L PATIENT INFORMATION LITERATURE

OUTCOMES: The patient will receive written information about metabolic syndrome.

STANDARDS:

1. Provide the patient with written information about metabolic syndrome.
2. Discuss the content of the patient information literature with the patient.

MSX-LA LIFESTYLE ADAPTATIONS

OUTCOMES: The patient will understand the lifestyle adaptations necessary to prevent or delay the progression of metabolic syndrome and develop a realistic plan to accomplish this.

STANDARDS:

1. Emphasize that healthy food choices and regular physical activity are the critical components in improving metabolic syndrome and preventing the progression to diabetes and cardiovascular disease.
2. Discuss the importance of tobacco cessation. Make referral to tobacco cessation programs if available.
3. Discuss the relationship of stress to metabolic syndrome and suggest ways to reduce stress. Refer to stress reduction program as appropriate.
4. Assist the patient to develop a self care plan.

MSX-M MEDICATIONS

OUTCOMES: The patient/family will understand their medication(s), regimen and the importance of fully participating in therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of the prescribed medications.
2. Discuss any drug-drug or drug-food interactions with this medication as appropriate.
3. Review clinical effects and onset of action expected with these medications.
4. Review recommended monitoring laboratory tests which may be ordered.
5. Explain importance of avoiding over-the-counter medications without checking with a physician and/or pharmacist.
6. Discuss common and important signs of toxicity and/or adverse reactions and what to do if the patient/family suspects a reaction.

MSX-N NUTRITION

OUTCOMES: The patient will understand the importance of nutritional management in the improvement of metabolic syndrome.

STANDARDS:

1. Refer to registered dietician as appropriate.
2. Emphasize that nutritional management includes meal planning, making healthy food choices, appropriate serving sizes and food preparation.
3. Review the food pyramid and its role in meal planning.
4. Explain how to read nutrition information labels. Emphasize the importance of noting the serving size – the serving size may not be the same as the container size.
5. Discuss the merits of various food preparation methods.
6. Describe appropriate portion size and emphasize its importance.
7. Discuss the importance of decreasing total fat intake and using healthier fats sparingly.
8. Explain that excessive salt intake may play a role in hypertension and discuss ways to decrease salt intake.

MSX-P PREVENTION

OUTCOME: The patient will understand ways to prevent cardiovascular disease and diabetes.

STANDARDS:

1. Explain that consuming a diet low in fat and cholesterol, controlling weight and exercising may help prevent complications from metabolic syndrome or progression to cardiovascular disease and diabetes.
2. Emphasize the importance of regular blood sugar, blood pressure, and lipid screening. Discuss current recommendations for screening and/or monitoring.
3. Explain that the metabolic syndrome tends to run in families and that the patient's family members should be evaluated by a physician or other health care provider.

MSX-SM STRESS MANAGEMENT

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

STANDARDS:

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

MSX-TE TESTS

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

STANDARDS:

1. Explain the test(s) ordered, i.e., FBS , A1C, Lipids.
2. Explain any necessary preparation prior to the test(s).
3. Explain the indications, risks and benefits of the test(s), including risks of not having the test(s) performed.
4. Explain the meaning of the test results in relation to what “normal” results are, as appropriate.
5. Explain the test as it relates to planning the course of treatment.

N

NDR—Near Drowning

NDR-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand the pathophysiology of near drowning.

STANDARDS:

1. Explain that the most important contribution to morbidity and mortality resulting from near drowning is hypoxemia and decrease in oxygen delivery to vital tissues.
2. Explain that the pathophysiology of near drowning is intimately related to the multiorgan effects of hypoxemia.
3. Explain that central nervous system (CNS) damage may occur as a result of hypoxemia sustained during the drowning episode or secondarily because of pulmonary damage and subsequent hypoxemia.
4. Explain that aspiration of fluid and vasoconstriction can result in significantly impaired gas exchange. Explain that acute respiratory distress syndrome (ARDS) may develop as a result of aspiration.
5. Explain that myocardial dysfunction may result from ventricular dysrhythmias and asystole due to hypoxemia. In addition, hypoxemia may directly damage the myocardium, decreasing cardiac output.
6. Explain that metabolic acidosis may impair cardiac function.

NDR-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications resulting from near drowning and how it relates to their specific condition.

STANDARDS:

1. Explain that the following may result from the near drowning experience:
   a. Neurologic injury (c spine or head trauma)
   b. Pulmonary edema or ARDS
   c. Secondary pulmonary infection
   d. Multiple organ system failure
   e. Acute tubular necrosis
   f. Myoglobinuria
   g. Hemoglobinuria
2. Explain that the risk of serious complications may be reduced by seeking prompt medical attention.

NDR-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of treatment and make a plan for appropriate follow-up.

STANDARDS:

1. Discuss the patient/family responsibility in follow-up care.
2. Discuss the individual treatment plan with the patient/family.
3. Discuss the procedure for obtaining follow-up appointments.

NDR-L LITERATURE

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

STANDARDS:

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

NDR-M MEDICATIONS

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

STANDARDS:

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

NDR-P PREVENTION

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

STANDARDS:

1. Explain that the key to the prevention of drowning is education.
2. Explain that parents should be aware of their own as well as their children's limitations around water.
3. Instruct patients to never swim alone and always supervise children when swimming.
4. Emphasize the importance of safe conduct around water and during boating and water or jet skiing.
5. Discourage the use of alcohol or recreational drugs while around water.
6. Encourage the use of appropriate boating equipment, (personal flotation devices)
7. Encourage the patient/family to be aware of weather and water conditions prior to boating or swimming.
8. Encourage patient/family members to learn CPR and rescue techniques.
9. Encourage patient/family to check water depth and underwater hazards (i.e., rocks, drop-offs, currents) prior to swimming and diving.
10. Emphasize the importance of providing fencing and locking gates around swimming pools.
11. Explain that the following medical conditions may increase risk for drowning:
    a. Seizure disorders
    b. Diabetes mellitus
    c. Significant coronary artery disease
    d. Severe arthritis
    e. Musculoskeletal disorders

NDR-TE TESTS

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

STANDARDS:

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

NF—Neonatal Fever

NF-C COMPLICATIONS

OUTCOME: The parent/family will understand the potential complications of neonatal fever.

STANDARDS:

1. Explain that neonatal fever may be the result of bacterial infection and that this may result in death, neurologic sequella, or physical deformity, as appropriate.
2. Discuss the need to have a neonate with fever evaluated immediately to decrease the risk of these complications.

NF-DP DISEASE PROCESS

OUTCOME: The parent/family will understand the possible etiologies of neonatal fever and why neonatal fever is so potentially devastating.

STANDARDS:

1. Explain that in the first 60 days of life an infant's immune system is not as competent at fighting infection as it is later in life. Explain that neonates are often unable to contain an infection in a certain body system and that the infection can become overwhelming and wide-spread in a very short period of time.
2. Explain that an infection, especially a bacterial infection can be fatal to a neonate.
3. Explain that fever can be a signal of many different things, among them, infections with various bacteria or viruses.
4. Discuss the need to have a neonate with fever evaluated immediately to decrease the risk of complications from neonatal infection.

NF-EQ EQUIPMENT

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

STANDARDS:

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

NF-FU FOLLOW-UP

OUTCOME: The parent/family will understand the importance of follow-up care for a neonate who has had fever and the procedure for obtaining follow-up care.

STANDARDS:

1. Explain that it is especially important to follow-up neonatal fever if the fever has been treated by outpatient management and that this follow-up should continue until the physician or provider has declared that the risk from the fever has past.
2. Explain that follow-up of neonatal fever that has been treated as an inpatient is important to assure that the infant has been fully treated and is recovering from the disease process that caused the fever.
3. Explain the process for making follow-up appointments and assist the parent/family as necessary in obtaining follow-up care.

NF-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

NF-M MEDICATIONS

OUTCOME: The parent/family will understand that the use of antibiotics is necessary in the treatment of neonatal fever until determination has been made that bacterial infection is not the causative agent of the fever.

STANDARDS:

1. Explain that because bacterial infections in neonates can be fatal extra caution is in order and many providers will give antibiotics before the causative agent has been identified. This is done to protect the neonate (with his/her incompletely developed immune system) from the potentially devastating consequences of bacterial infection.
2. Discuss the common and important side effects of the medications to be used.
3. Discuss drug/drug or drug/food interactions as appropriate.

NF-P PREVENTION

OUTCOME: The parent/family will understand that neonatal fever can often be prevented and the measures to take to prevent the neonate from becoming infected.

STANDARDS:

1. Explain that because an infant in the first 60 days of life has a less competent immune system it is important to protect him/her from germs (bacteria/viruses).
2. Explain that bacteria and viruses are usually passed from one human to another.
3. Explain that it is important to keep the neonate out of public places for the first 60 days of life to decrease his/her exposure to other humans. (Public places or any place one can reasonably anticipate seeing more than 4 or 5 people, i.e., such as grocery stores, department stores, ball games, school functions, restaurants.)
4. Explain that hand washing at home is an effective way to prevent the spread of bacteria and viruses in the home.
5. Explain that family members who become ill should avoid contact with the neonate if at all possible. (The possible exception to this being the nursing mother who is providing for the infant, antibodies to her illness through breastmilk.)
6. Explain that breastfeeding improves the neonates immune system by the passing of antibodies to the infant in the mother's milk.

NF-TE TESTS

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

STANDARDS:

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

NJ—Neonatal Jaundice

NJ-C COMPLICATIONS

OUTCOME: The family will understand the common or serious complications of neonatal jaundice.

STANDARDS:

1. Explain that the most common complication of neonatal jaundice is lethargy resulting in decreased feeding followed by increased dehydration and worsening jaundice.
2. Explain that the most serious complication of neonatal jaundice is acute bilirubin encephalopathy and kernicterus.
3. Emphasize the importance of watching for jaundice and seeking medical care if jaundice is noticed to prevent complications.
4. Discuss complications associate with treatment of neonatal jaundice:
    a. Eye damage from phototherapy lights
    b. Dehydration
    c. Blood born pathogens from exchange transfusions
    d. Delay in the bonding process
    e. Complicates breastfeeding

NJ-DP DISEASE PROCESS

OUTCOME: The family will understand the basic pathophysiology of neonatal jaundice.

STANDARDS:

1. Explain that over ½ of newborns develop some degree of jaundice.
2. Explain that neonatal jaundice is characterized by yellow discoloration of the skin and in some cases the whites of the eyes.
3. Explain that the yellow discoloration is caused by a chemical in the blood called bilirubin which is a breakdown product of red blood cells.
4. Discuss that everyone is breaking down red blood cells and producing new ones constantly.
5. Explain that in-utero the bilirubin is broken down by the mother's liver but the most common reason for neonatal jaundice is immaturity of the newborn's liver enzymes which are unable to break down the bilirubin fast enough to prevent jaundice.
6. Discuss other less common reasons for jaundice as appropriate:
    a. Maternal antibodies against the newborn's blood resulting in hemolysis
    b. Extensive bruising or cephalohematoma secondary to the birth process
    c. Dehydration or excessive weight loss after birth
    d. Prematurity
    e. G6PD deficiency resulting in hemolysis
    f. Other hemolytic processes
7. Explain, as appropriate, that some individuals are at higher for development of jaundice:
    a. Persons whose sibling required phototherapy
    b. Infants less than 38 weeks gestation
    c. Breastfed infants, especially when there is difficulty initiating breastfeeding
    d. Macrosomic infants of gestational diabetic mothers
    e. Infants with significant weight loss
    f. Infants born to mothers >25 years of age
    g. Male infants

NJ-P PREVENTION

OUTCOME: The family will understand the measures that may prevent jaundice or complications from jaundice.

STANDARDS:

1. Explain that breastfeeding 8-12 times per day will help to prevent jaundice or significant complications from jaundice.
2. Emphasize the importance of watching for jaundice and seeking medical care if jaundice is noticed to prevent complications.
3. Emphasize that the evaluation of blood bilirubin levels as soon as jaundice is identified can help reduce complications by initiating therapy when indicated.
4. Explain that interventions such as medical phototherapy or exchange transfusions can decrease the incidence of complications such as acute bilirubin encephalopathy and kernicterus.

NJ-TE TESTS

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

STANDARDS:

1. Explain that there are two ways to test for bilirubin levels:
   a. blood bilirubin levels (more accurate)
   b. Transcutaneous bilirubinometer
2. Emphasize that visual estimation of bilirubin levels leads to errors.
3. Explain that numerous blood draw may be necessary as following levels bilirubin levels and other lab tests closely is necessary to avoid complications.

NJ-TX TREATMENT

OUTCOME: The family will understand the treatment plan.

STANDARDS:

1. Discuss that exposing the infants to sunlight is no longer recommended to lower bilirubin levels due to the risks of exposure.
2. Explain that medical phototherapy lowers bilirubin levels by breaking down bilirubin through the skin.
3. Explain that exchange transfusion may be necessary for dangerously high bilirubin levels or if acute bilirubin encephalopathy is identified.

ND—Neurological Disorder

ND-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.

ND-DP DISEASE PROCESS

OUTCOME: The patient and/or family members will understand the patient's neurological disease process.

STANDARDS:

1. Review the anatomy and physiology of the nervous system as it relates to the patient's disease process and its relationship to the patient's activities of daily living.
2. Discuss the pathophysiology of the patient's neurological disorder and how it may affect function and lifestyle.

ND-EQ EQUIPMENT

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

STANDARDS:

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

ND-EX EXERCISE

OUTCOME: The patient and/or family members will understand the importance of exercise in enhancing physical and psychological well-being.

STANDARDS:

1. Explain the hazards of immobility. Discuss how to prevent decubitus ulcers, contractures, constipation, renal calculi, isolation and a loss of self-esteem.
2. Emphasize that physical activity/therapy is an integral part of the patient's daily routine. Make referrals as indicated.
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.

ND-FU FOLLOW-UP

OUTCOME: The patient and /or family members will recognize the importance of routine follow-up as an integral part of health care and maintenance.

STANDARDS:

1. Discuss the importance of routine follow-up by the primary provider, social services, physical therapy, mental health services, registered dietician and community health services.
2. Assess the need for any additional follow-up and make the necessary referrals.

ND-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about neurologic disease.

STANDARDS:

1. Provide the patient/family with written patient information literature on neurologic disease.
2. Discuss the content of the patient information literature with the patient/family.

ND-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient and/or family members will understand what lifestyle adaptations are necessary to cope with the patient's specific neurological disorder.

STANDARDS:

1. Assess the patient's and family's level of acceptance of the disorder.
2. Refer to Social Services, Mental Health, Physical Therapy, Rehabilitative Services, and/or community resources as appropriate.
3. Review the lifestyle areas that may require adaptations: diet, physical activity, sexual activity, bladder/bowel habits, role changes, communication skills and interpersonal relationships.
4. Refer to occupational therapy as indicated for assistance with activities of daily living.

ND-M MEDICATIONS

OUTCOME: The patient and/or family members will understand the goals of drug therapy, the side effects of the medications and the importance of fully participating in the medication regimen.

STANDARDS:

1. Review mechanisms of action for patient's medication.
2. Discuss the proper use, benefits and common side effects of the patient's prescribed medications. Review signs of possible medication toxicity as indicated.
3. Emphasize the importance of fully participating in the medication regimen.

ND-N NUTRITION

OUTCOME: The patient and/or family members will understand what dietary modification may be necessary for a patient with a neurological disorder.

STANDARDS:

1. Review the feeding technique appropriate for the patient.
2. Identify problems associated with feeding a neurologically impaired patient:
   a. Motor impairment: Feeding may take more time, swallowing may be difficult and aspiration is a risk.
   b. Sensory impairment: Loss of taste. Inability to sense temperature may result in burns.
3. Consider referral to Social Services for help in obtaining equipment and home health services.

ND-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the importance of appropriate management of pain.

STANDARDS:

1. Explain that neuropathic pain may be significant and needs to be discussed with the medical provider.
2. Explain that the use of over the counter medications for chronic pain management needs to be assessed by the medical provider to minimize risk to kidney function.
3. Explain that all chest pain must be evaluated by the medical provider to rule out the possibility of myocardial infarction.

ND-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient and/or appropriate family member(s) will understand the importance of injury prevention and implement safety measures.

STANDARDS:

1. Explain to patient and family members the importance of body mechanics and proper lifting techniques to avoid injury.
2. Assist the family in identifying ways to adapt the home to improve safety and prevent injuries, i.e., remove throw rugs, install bars in tub/shower, secure electrical cords.
3. Stress importance and proper use of mobility devices (cane, walker, wheel chair).

ND-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.

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.

OM—Otitis Media

OM-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of OM.

STANDARDS:

1. Discuss the effects of chronic OM and/or chronic middle ear fluid, including the possibility of permanent hearing loss.
2. Discuss tympanic membrane perforation as a complication of OM.
3. Discuss the possibility of mastoiditis, as appropriate. Explain that this is extremely rare.

OM-DP DISEASE PROCESS

OUTCOME: The patient/family will better understand the causes and effects of otitis media.

STANDARDS:

1. Explain the anatomy of the middle ear.
2. Explain the pathophysiology of otitis media.
3. Discuss the myths and facts about otitis media, i.e., things that do and do not cause OM.
4. Explain the long-term effects of chronic OM as appropriate.

OM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of OM.

STANDARDS:

1. Discuss the importance of assessing the effectiveness of therapy as it relates to prevention of complications of OM.
2. Emphasize that the only way to assess the effectiveness of therapy is to have the ears re-examined.

OM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about otitis media.

STANDARDS:

1. Provide the patient/family with written patient information literature on otitis media.
2. Discuss the content of the patient information literature with the patient/family.

OM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand how changes in lifestyle can impact OM.

STANDARDS:

1. Discuss the importance of assessing the effectiveness of therapy as it relates to prevention of complications of OM.
2. Explain the negative effect of passive smoking. Discourage smoking in the home and car.
3. Explain that drinking from a bottle, especially in a supine position increases the likelihood of developing OM. Encourage weaning from the bottle at one year of age. **Refer to CHT-W.**

OM-M MEDICATIONS

OUTCOME: The patient/ family will understand the use of medications in OM.

STANDARDS:

1. Discuss the use, benefits and common side effects of the prescribed medication.
2. Discuss the importance of completing the course of antibiotics (to eradicate the infection and reduce the likelihood of emergence of resistant organisms).
3. Discuss the indications for and use of chronic suppressive antibiotics as appropriate.
4. Discuss the use of analgesia in pain control. **Refer to OM-PM.**

OM-P PREVENTION

OUTCOME: The patient/family will understand some ways to decrease recurrence of OM.

STANDARDS:

1. Discuss that breastfeeding decreases the incidence of OM by passage of maternal antibodies in breastmilk.
2. Discuss that exposure to cigarette smoke increases the probability of OM. Encourage parents and other caregivers to never smoke in a home or car where a child will be.
3. Discourage bottle propping or feeding the infant from a bottle in the supine position as this increases the likelihood of developing OM. Encourage weaning from the bottle at one year of age. Refer to CHT-W.

OM-PET PRESSURE EQUALIZATION TUBES

OUTCOME: The patient/family will understand the purpose and important complications of pressure equalization tubes.

STANDARDS:

1. Discuss what PET are and how they work.
2. Discuss the common and important complications of surgery and anesthesia. **Refer to ANS and SPE.**
3. Discuss the 1% chance of chronic tympanic membrane perforation after PET placement.
4. Discuss the importance of protecting the ears from water after PET placement.

OM-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications (such as acetaminophen or non-steroidal anti-inflammatory) may be helpful to control the symptoms of pain.
4. Discuss non-pharmacologic measures that may be helpful with pain control, i.e., warm packs.

OM-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.

P

PNM—Pneumonia

PNM-C COMPLICATIONS

OUTCOME: The patient will be able to relate the possible complications, the symptoms that should be reported, and the appropriate actions to prevent complications.

STANDARDS:

1. Discuss the possible complications, e.g. pleural effusion, sustained hypotension and shock, other infections such as bacteremia, and atelectasis due to mucus plugs.
2. Explain that complications may be prevented with prompt treatment with appropriate antibiotics and therapy.
3. Advise patient/family to return if cough, fever or shortness of breath worsen or do not improve.

PNM-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PNM-DP DISEASE PROCESS

OUTCOME: The patient will understand pneumonia and its symptoms.

STANDARDS:

1. Explain that pneumonia is an inflammatory process, involving-the terminal airways and alveoli of the lung and is caused by infectious agents.
2. Explain that pneumonia may be contracted by aspiration of oropharyngeal contents, by inhalation of respiratory secretions from infected individuals, through the bloodstream, or directly during surgery or trauma.
3. Explain that patients with bacterial pneumonia may have had an underlying disease that impairs the defenses, such as a preceding viral illness.
4. Explain that weakness and fatigue may persist for weeks after the infection. Encourage a gradual return to normal activities.

PMN-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

PNM-EX EXERCISE

OUTCOME: The patient will be able to demonstrate appropriate deep breathing and coughing exercises.

STANDARDS:

1. Instruct patient in deep breathing, exercises.
2. Instruct patient in techniques to cough effectively.

PNM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

PNM-IS INCENTIVE SPIROMETRY

OUTCOME: The patient will understand the reason for use incentive spirometer and demonstrate appropriate use.

STANDARDS:

1. Explain that regular and appropriate use of the incentive spirometer according to instructions reduces the risk of respiratory complications including pneumonia.
2. Explain that the optimal body position for incentive spirometry is semi-Fowler's position which allows for free movement of the diaphragm.
3. Instruct the patient to exhale normally and evenly inhale maximally through the spirometer mouthpiece.
4. Encourage the patient to hold the maximal inspiration for a minimum of three seconds to allow for redistribution of gas and opening of atelectatic areas.
5. Instruct the patient to exhale slowly and breathe normally between maneuvers.
6. Instruct the patient to repeat this maneuver as frequently as prescribed.

PNM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about pneumonia.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding pneumonia.
2. Discuss the content of the patient information literature with the patient/family.

PNM-M MEDICATIONS

OUTCOME: The patient and/or family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Review the proper use, benefits and common side effects of prescribed medications.
2. Explain the importance of completing the full course of antibiotic therapy, as prescribed, to prevent antibiotic resistance and to facilitate complete recovery.
3. Explain the importance of adhering to the medication schedule.
4. Discuss the use of medications for symptom relief, i.e., expectorants, analgesics.
5. Discourage the use of cough suppressants for a productive cough.

PNM-N NUTRITION

OUTCOME: The patient will understand how to modify the diet to conserve energy and promote healing.

STANDARDS:

1. Stress the importance of water intake to aid in liquefying sputum.
2. Discuss the importance of the food pyramid and maintaining a balanced diet to maintain health.
3. Discuss the essential role of protein in healing.
4. Discuss changing to frequent small meals to conserve energy during the acute phase of pneumonia as appropriate.

PNM-P PREVENTION

OUTCOME: The patient/family will understand actions that may be taken to prevent pneumonia.

STANDARDS:

1. Instruct patient to avoid contact with people with upper respiratory infections.
2. Encourage patient to maintain natural resistance to infection through adequate nutrition, rest, and exercise.
3. Encourage patient (particularly if elderly or chronically ill) to obtain immunizations against influenza and pneumococcus.

PNM-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand actions that may be taken to control chest discomfort.

STANDARDS:

1. Encourage the patient to take analgesics as prescribed for chest discomfort.
2. Demonstrate how to splint the chest while coughing.

PNM-TE TESTS

OUTCOME: The patient will understand the test(s) to be performed.

STANDARDS:

1. Explain that pneumonia may be diagnosed by evidence on the chest x-ray.
2. Explain that the specific infective organism can be diagnosed from a sputum culture and gram stain. The most effective antibiotics to treat the pneumonia can be identified from a sensitivity test of the cultured organism.
3. Explain that blood cultures and blood counts may also assist in diagnosis and treatment.
4. Discuss the risks/benefits of tests ordered.

PNM-TX TREATMENT

OUTCOME: The patient/family will understand the appropriate treatment for pneumonia and the importance of fully participating with the prescribed regimen.

STANDARDS:

1. Explain that antibiotics are necessary to obliterate the infective organisms. **Refer to PNM-M.**
2. Explain that sometimes oxygen is required during the acute phase of infection to maintain adequate oxygenation.

POI—Poisoning

POI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of the treatment plan and the importance of making and keeping follow-up appointments.

STANDARDS:

1. Explain the recommended schedule for follow-up.
2. Explain the procedure for obtaining follow-up appointments
3. Explain the importance of keeping follow-up appointments.
4. Explain that failure to keep follow-up appointments may have devastating consequences.

POI-I INFORMATION

OUTCOME: The patient/family will understand the steps to take when an incident of poisoning has been identified.

STANDARDS:

1. Discuss the importance of calling the Poison Control Center immediately.
2. Emphasize that immediate treatment increases the probability of a positive outcome.
3. Explain the importance of having the substance causing the poisoning available. Explain how this will assist medical personnel in making a correct diagnosis and treatment plan.
4. Discuss the use of syrup of ipecac. Explain that ipecac should only be used on the advice of the poison control center or medical personnel.

POI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about poison prevention.

STANDARDS:

1. Provide the patient/family with written information about poison prevention.
2. Discuss the content of the patient information literature with the patient/family.

POI-P PREVENTION

OUTCOME: The parent/family will understand necessary steps to poison prevention.

STANDARDS:

1. Discuss ways to poison proof the home by keeping poisons and medications stored safely and out of reach of children, keep medicines and poisons in their original containers, and lock up cabinets containing poisons that are within reach of children.
2. Explain to parents the necessity of discussing poison control with their children. Emphasize to parents to impress upon their children that medication is not candy.
3. Emphasize that child-locks, child-resistant medication containers and other child safety devises are not truly child proof.
4. Explain that poisonous chemicals should not be stored in food or drink containers. Poisonous chemical should be kept in original, properly labeled containers.

POI-TE TESTS

OUTCOME: The patient /family will understand the conditions under which testing is necessary and the specific test(s) to be preformed, technique for collecting samples and the expected benefit of testing and any associated risks. The patient/family will also understand alternatives to testing and the potential or risks associated with the alternatives, i.e., risk of non-testing.

STANDARDS:

1. Explain that tests may be necessary for diagnosis and treatment of poisoning and for follow-up of treatment. Discuss the procedure for collecting the sample, the benefit expected and any associated risks.
2. Explain the alternatives to the proposed test(s) and the risk(s) and benefits(s) of the alternatives including the risk of non-testing.

POI-TX TREATMENT

OUTCOME: The patient/family will understand the components of the treatment plan as well as common and important side-effects, risks and benefits and the probability of success of the treatment. The patient/family will further understand the risk of non-treatment.

STANDARDS:

1. Emphasize that immediate treatment increases the probability of a positive outcome.
2. Explain the importance of having the substance causing the poisoning available. Explain how this will assist medical personnel in making a correct diagnosis and treatment plan.
3. Discuss the use of syrup of ipecac. Explain that ipecac should only be used on the advice of the poison control center or medical personnel.
4. Discuss the treatment plan for this specific poisoning. Discuss suicide precautions if this was a non-accidental poisoning. **Refer to SB.**

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.

PSR—Psoriasis

PSR-BH BEHAVIORAL HEALTH

OUTCOME: The patient will understand that psoriasis has a physical impact on the skin, but it also affects feelings, behaviors, and experiences.

STANDARDS:

1. Discuss the importance of recognizing and acknowledging the social effects of psoriasis in order to cope with the disease.
2. Explain that psoriasis marks people as different because the skin looks different from other people's skin. Some people may react with insensitivity and ignorance to people with psoriasis.
3. Discuss that ways to cope with psoriasis will vary with individuals, and that there is no "best" way to cope with psoriasis. Coping might include discussing this condition with family and friends.
4. Discuss emotions associated with psoriasis, i.e., frustration with the condition, embarrassment, anger.
5. Discuss ways to cope with the emotional aspects of psoriasis:
    a. Learn the facts about psoriasis
    b. Practice responses to people who may comment on your skin
    c. Join (or start) a psoriasis support group
    d. Expect negative experiences but anticipate that each time it will get easier
    e. Fill life with a positive focus
    f. Remember that there is much more to life than just the skin disease
6. Refer to community resources as appropriate.

PSR-DP DISEASE PROCESS

OUTCOME: The patient will understand the basic pathophysiology, symptoms, and prognosis of psoriasis.

STANDARDS:

1. Explain that psoriasis is not contagious, there is no cure, and will require lifelong treatment. Psoriasis comes and goes in cycles of remission and flare-ups.
2. Explain that a variety of factors – ranging from emotional stress, trauma to the skin, dry skin and streptococcal infection – can induce an episode of psoriasis. Recent research indicates that some abnormality in the immune system likely plays a role.
3. Explain that in people with psoriasis; the immune system is mistakenly "triggered," causing skin cells to grow too fast. The rapidly growing cells pile up in the skin's top layers, leading to the formation of silvery lesions on the surface.
4. Explain that genetics may play a role and that psoriasis may be exacerbated by:
    a. Emotional stress
    b. Injury to the skin
    c. Reaction to certain drugs
    d. Some types of infection
5. Explain that psoriasis is a skin disease that causes dry, red, scaly patches to appear on the skin. It can show up on any part of the body. In most cases, it occurs on the elbows, knees, scalp, or torso.
6. Discuss the forms of psoriasis as indicated for this patient.
    a. Plaque psoriasis (most common): patches of raised, red skin covered by a flaky white or silver build-up called scale.
    b. Guttate psoriasis: sometimes preceded by strep throat. Small, red dots on the skin usually appear on the arms, legs, and trunk.
    c. Three less common forms of psoriasis:
        i. Erythrodermic – intense inflammation with bright, red skin that looks "burned" and sheds or peels.
        ii. Inverse – smooth, dry patches that are red and inflamed, often in the folds or creases of the skin, such as the armpits or groin, between the buttocks or under the breasts. Inverse psoriasis is more common in those who are overweight.
        iii. Pustular – blister like spots filled with liquid, surrounded by red skin. The blisters will often come and go in cycles. This form of psoriasis can appear on specific areas, like the hands or feet, or on larger areas of skin.
7. Later manifestations of psoriasis may include:

a. Palmer/Plantar psoriasis: red, scaly, cracked skin with tiny pustules on the palms of the hands or the soles of the feet.

b. Psoriatic arthritis:

i. Stiffness, pain, and tenderness of the joints

ii. Reduced range of motion

iii. Nail changes such as pitting, which is found in up to 80% of people with psoriatic arthritis

8. Explain that usually people have one kind of psoriasis at a time. However, one kind of psoriasis can turn into another kind.

9. Psoriasis can be:

a. Mild - up to 3% of your body

b. Moderate – 3 to 10% of your body

c. Severe – more than 10% of your body

PSR-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.

PSR-L PATIENT INFORMATION LITERATURE

OUTCOME - The patient/family will receive written information about psoriasis.

STANDARDS:

1. Provide patient/family with written patient information on psoriasis
2. Discuss the content of patient information literature with the patient/family.

PSR-M MEDICATIONS

OUTCOME: The patient will understand some of the medications available in the treatment of psoriasis.

STANDARD:

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.
6. Explain that the severity of psoriasis will determine which medication is needed.
7. Explain that no single medication works for everyone and that the goal is to find medications that work best with the fewest side effects.
8. Explain that different kinds of prescription and over-the-counter treatments can help with psoriasis.
9. Explain that Methotrexate and other immune modifying agents can provide dramatic results: however, may result in severe liver damage, immune suppression, and other complications and may require frequent blood tests.

PSR-N NUTRITION

OUTCOME: The patient/family will understand the need for a healthy diet pertaining to psoriasis.

STANDARDS:

1. Review normal nutritional needs for optimal health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Explain that vitamin D and E and Zinc may have some benefit.
4. Refer to a dietitian as needed.

PSR-P PREVENTION

OUTCOME: The patient will understand that avoiding psoriasis triggers can lessen the impact of the condition.

STANDARDS:

1. Explain that the patient should avoid skin injuries that result in a break in the skin which can exacerbate or trigger flare-ups, i.e., insect bites, cuts and scrapes, and burns. Emphasize that care should be taken to wear protective clothing to protect the skin.
2. Explain that other triggers that may exacerbate psoriasis include shaving, adhesive taping, tattoos, chafing, blisters, and boils.
3. Explain that common preventive measures include avoiding hot showers and perfumed lotions and soaps.
4. Explain that it is difficult to separate job and family-related stress from the psychological stress of living with psoriasis. One cause of stress probably reinforces the others. Clinical studies have supported the facts that psychological stress can worsen psoriasis. **Refer to PSR-SM.**

PSR-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management with psoriasis.

STANDARDS:

1. Explain that uncontrolled stress can contribute to increased outbreaks.
2. Explain that effective stress management may reduce the adverse consequences of psoriasis, 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:
    d. becoming aware of your own reactions to stress
    e. recognizing and accepting your limits
    f. talking with people you trust about your worries or problems
    g. setting realistic goals
    h. getting enough sleep
    i. maintaining a reasonable diet
    j. exercising regularly
    k. taking vacations
    l. practicing meditation
    m. self-hypnosis
    n. using positive imagery
    o. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    p. spiritual or cultural activities
4. Provide referrals as appropriate.

PSR-TX TREATMENT

OUTCOME: The patient will understand that psoriasis usually responds to treatment but is not curable.

STANDARDS:

1. Explain that a simple treatment for psoriasis is to soak in a warm bath for 10-15 minutes, then immediately apply a topical ointment such as petroleum jelly, which helps the skin retain moisture.
2. Explain that topical ointments include salicylic acid ointments, steroid-based creams, and ointments containing calcipotriene, which is related to vitamin D.
3. Explain that coal-tar ointments and shampoos can alleviate symptoms but these may also cause side effects, such as folliculitis.
4. Explain that light therapy treatment is sometimes recommended for persistent, difficult-to-treat cases of psoriasis. However, the use of light therapy can be risky due to the possibility of skin damage from the ultraviolet light itself.
5. Explain that when these treatments fail, some doctors prescribe oral medications to treat psoriasis. Some of these medications affect the immune system and body organs and require careful monitoring.

PL—Pulmonary Disease

PL-BIP BILEVEL (OR CONTINUOUS) POSITIVE AIRWAY PRESSURE VENTILATION

OUTCOME: The patient/family will have a basic understanding of BiPAP or CPAP ventilation, as well as the risks, benefits, alternatives to BiPAP or CPAP and associated factors affecting the patient.

STANDARDS:

1. Explain that the patient does not require intubation with an endotracheal tube or tracheostomy tube in order to receive BiPAP or CPAP. BiPAP or CPAP is delivered utilizing a tight-fitting mask over the nose and/or mouth.
2. Explain the basic mechanics of BiPAP or CPAP, including the risks and benefits of receiving BiPAP or CPAP and the adverse events which might result from refusal.
3. Discuss alternatives to BiPAP or CPAP, including expectant management, endotracheal intubation or tracheostomy as appropriate.
4. Explain that patient cooperation is vital to successful BiPAP or CPAP management.

PL-C COMPLICATIONS

OUTCOME: The patient will understand how to prevent complications of pulmonary disease.

STANDARDS:

1. Discuss that the most common complications of pulmonary disease are exacerbation or infection. These complications often result from failure to fully participate with treatment regimens (i.e., medications, peak flows) or from exposure to environmental triggers or infections.
2. Emphasize early medical intervention for minor URI's, fever, cough, and shortness of breath.
3. Stress the importance of fully participating in the treatment plan.

PL-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PL-DP DISEASE PROCESS

OUTCOME: The patient will understand the etiology and pathophysiology of their pulmonary disease.

STANDARDS:

1. Review the anatomy and physiology of the respiratory system.
2. Discuss how factors such as: environmental triggers, age, smoking, COPD, and asthma affect the ability of the respiratory system to exchange O_2/CO_2 and resist infection.
3. Discuss the pathophysiology of the patient's specific disease process.

PL-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

PL-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in this patient's disease process and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
2. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
3. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
4. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
5. Discuss medical clearance issues for physical activity.

PL-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of regular follow-up and will strive to keep scheduled appointments.

STANDARDS:

1. Discuss the importance of regular follow-up care in the prevention of complications and adjustment of medications.
2. Encourage full participation in the treatment plan. Assess the patient's understanding of the treatment plan and acceptance of the diagnosis.
3. Provide positive reinforcement for areas of achievement.
4. Refer to PHN or community resources as appropriate.
5. Emphasize the importance of consistent peak flow measurement if appropriate.

PL-HM HOME MANAGEMENT

OUTCOME: The patient and/or family will understand the home management of their disease process and make a plan for implementation.

STANDARDS:

1. Discuss home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer emergency room visits and fewer hospitalizations.

PL-INT INTUBATION

OUTCOME: The patient/family will have a basic understanding of endotracheal intubation, as well as the risks, benefits, alternatives to endotracheal intubation and associated factors affecting the patient.

STANDARDS:

1. Explain the basic procedure for endotracheal intubation, including the risks and benefits of endotracheal intubation and the adverse events which might result from refusal.
2. Discuss alternatives to endotracheal intubation, including expectant management, as appropriate.
3. Explain that the patient will be unable to speak or eat while intubated.

PL-IS INCENTIVE SPIROMETRY

OUTCOME: The patient will understand the reason for use of the incentive spirometer and demonstrate appropriate use.

STANDARDS:

1. Explain that regular and appropriate use of the incentive spirometer according to instructions reduces the risk of respiratory complications including pneumonia.
2. Explain that the optimal body position for incentive spirometry is semi-Fowler's position which allows for free movement of the diaphragm.
3. Instruct the patient to exhale normally and evenly inhale maximally through the spirometer mouthpiece.
4. Encourage the patient to hold the maximal inspiration for a minimum of three seconds to allow for redistribution of gas and opening of atelectatic areas.
5. Instruct the patient to exhale slowly and breathe normally between maneuvers.
6. Instruct the patient to repeat this maneuver as frequently as prescribed.

PL-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about pulmonary disease.

STANDARDS:

1. Provide the patient/family with written patient information literature on pulmonary disease.
2. Discuss the content of the patient information literature with the patient/family.

PL-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will strive to make the lifestyle adaptations necessary to prevent complications of pulmonary disease and prolong life.

STANDARDS:

1. Discuss lifestyle changes which the patient has the ability to make: cessation of smoking, dietary modifications, weight control, participation in treatment and exercise.
2. Re-emphasize how complications of pulmonary disease can be reduced or eliminated by such changes.
3. Review the community resources available to help the patient in making such lifestyle changes.
4. Identify and avoid environmental triggers (i.e., cigarette smoke, stress, environmental smoke, pollen, mold, dust, roaches, insecticides, paint fumes, perfumes, animal dander, cold air, sulfites, aspirin) as appropriate for the patient.

PL-M MEDICATIONS

OUTCOME: The patient and/or family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Review the patient's medications. Reinforce the importance of knowing the drug, dose, and dosing interval of medications.
2. Review common side effects, signs of toxicity, and drug interactions of medication(s).
3. Discuss the difference between bronchodilator and anti-inflammatory medications.
4. Explain the difference between maintenance and rescue drugs.
5. Emphasize full participation with the treatment plan and explain how effective use of medications can facilitate a more active life style for the pulmonary disease patient.
6. Emphasize the importance of consulting with a health care provider prior to using any OTC medication.

PL-MDI METERED-DOSE INHALERS

OUTCOME: The patient will be able to demonstrate correct technique for use of MDIs and understand their role in the management of pulmonary disease.

STANDARDS:

1. Instruct and demonstrate steps for standard or alternate use procedure for metered-dose inhalers and ways to clean and store the unit properly.
2. Review the importance of using consistent inhalation technique.

PL-N NUTRITION

OUTCOME: The patient will understand how to modify diet to conserve energy and promote nutritional balance.

STANDARDS:

1. Assess the patient's current nutritional patterns. Review how these patterns might be improved.
2. **Refer to WL-N.**
3. Stress the importance of water intake to aid in liquefying sputum.
4. Explain how meal planning may need to be individualized for specific pulmonary disorders. Consider eliminating milk because it increases mucous production. Foods which are gas producing may hinder diaphragmatic movement. Several small meals instead of three large meals may be indicated to reduce respiratory effort. Refer to dietitian as appropriate.

PL-NEB NEBULIZER

OUTCOME: The patient will be able to demonstrate effective use of the nebulizer device, discuss proper care and cleaning of the system, and describe its place in the care plan.

STANDARDS:

1. Describe proper use of the nebulizer including preparation of the inhalation mixture, inhalation technique, and care of equipment.
2. Discuss the nebulizer treatment as it relates to the medication regimen.

PL-O2 OXYGEN THERAPY

OUTCOME: The patient and/or family will understand the need for and be able to demonstrate the proper use of oxygen administration equipment.

STANDARDS:

1. Discuss the dangers of ignition sources around oxygen, i.e., cigarettes, sparks, flames.
2. Emphasize the importance of regular maintenance checks of oxygen equipment.
3. Emphasize that O2 flow rate should not be changed except upon the order of a physician, since altering the flow rate may worsen the condition.
4. Discuss use, care, and cleaning of all equipment.
5. Explain the reason for O_2 therapy and the anticipated benefit.

PL-PF PEAK-FLOW METER

OUTCOME: The patient will be able to demonstrate correct use of the peak-flow meter and explain how its regular use can help achieve a more active lifestyle.

STANDARDS:

1. Discuss use and care of the peak flow meter as a tool for measurement of peak expiratory flow rate (PEFR) and degree of airway obstruction. Discuss peak flow zones in management of airway disease.
2. Explain how monitoring measurement of PEFR can provide an objective way to determine current respiratory function.
3. Emphasize how a regular monitoring schedule can help determine when emergency care is needed, prevent exacerbations through early intervention, and facilitate management of the pulmonary disease.

PL-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient; and may be multifaceted. **Refer to PM.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Explain non-pharmacologic measures that may be helpful with pain control.

PL-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure(s), as well as the risks, benefits, alternatives to the proposed procedure(s) and associated factors affecting the patient.

STANDARDS:

1. Explain the specific procedure(s) to be performed, including the risks and benefits of performing the procedure and the adverse events which might result from refusal of the procedure.
2. Discuss alternatives to the proposed procedure(s), including expectant management, as appropriate.
3. Discuss the expected patient/family involvement in the care required following the proposed procedure(s).

PL-SHS SECOND-HAND SMOKE

OUTCOME: Provide the patient and/or family with an understanding of the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls.
2. Discuss harmful substances in smoke
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness in the pulmonary patient when exposed to cigarette smoke either directly or via second-hand smoke.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the pulmonary patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage smoking cessation or at least never smoking in the home or car.

PL-SPA SPACERS

OUTCOME: The patient will be able to demonstrate the correct use of spacers and understand their importance in delivery of medications.

STANDARDS:

1. Instruct and demonstrate proper technique for spacer use.
2. Discuss proper care and cleaning of spacers.
3. Explain how spacers improve the delivery of inhaled medications.

PL-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

PL-TO TOBACCO (SMOKING)

OUTCOME: The patient and/or family will understand the dangers of smoking or exposure of the pulmonary patient to cigarette smoke and develop a plan to eliminate said exposure.

STANDARDS:

1. Explain the increased risk of illness in the pulmonary patient when exposed to cigarette smoke either directly or via second-hand smoke.
2. Explain that cigarette smoke gets trapped in carpets and upholstery and still increases the risk of illness even if the pulmonary patient is not in the room at the time that the smoking occurs.
3. Encourage smoking cessation or at least NEVER smoking in the home or car.
4. **Refer to TO.**

PL-VENT MECHANICAL VENTILATION

OUTCOME: The patient/family will understand mechanical ventilation, as well as the risks, benefits, alternatives to mechanical ventilation and associated factors affecting the patient.

STANDARDS:

1. Explain that the patient must be intubated with an endotracheal tube or tracheostomy tube in order to receive mechanical ventilation.
2. Explain the basic mechanics of mechanical ventilation, including the risks and benefits of receiving mechanical ventilation and the adverse events which might result from refusal.
3. Discuss alternatives to mechanical ventilation, including expectant management, as appropriate.
4. Explain that the patient will be unable to speak or eat while intubated and receiving mechanical ventilation.
5. Explain that the patient will be sedated during intubation and the initiation of mechanical ventilation.
6. Discuss the possibility that the patient may require restraints to prevent accidental extubation.

R

XRAY—Radiology/Nuclear Medicine

XRAY-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and important complications that may result from this procedure.

STANDARDS

1. Explain that some patients may have adverse reactions to contrast media or other medications used during radiographic/nuclear medicine procedures.
2. Discuss common and important complications as they apply to the procedure to be performed.
3. Discuss the procedure that will be undertaken if adverse events occur.

XRAY-FU FOLLOW-UP

OUTCOME: The patient/family will understand the conditions that would require follow-up and how to obtain follow-up.

STANDARDS:

1. Discuss the findings that will signify a serious complication or condition.
2. Discuss the procedure for obtaining follow-up appointments.

XRAY-L LITERATURE

OUTCOME: The patient/family will receive written information about the disease process or condition.

STANDARDS:

1. Provide patient/family with written patient information on the disease state or condition.
2. Discuss the content of patient information literature with the patient/family.

XRAY-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of medication therapy as it relates to the procedure to be performed.

STANDARDS:

1. Discuss the proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
2. Emphasize the importance of full participation with medication regimen.
3. Discuss the mechanism of action as needed.
4. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
5. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

XRAY-PRO PROCEDURE

OUTCOME: The patient/family will understand the radiographic/nuclear medicine procedure to be performed.

STANDARDS:

1. Discuss the method of the radiographic/nuclear medicine procedure that has been ordered.
2. Discuss the indications, risks, and benefits for the proposed procedure.
3. Explain the process and what to expect after the procedure.
4. Explain the necessary preparation, i.e., bowel prep, diet instructions, bathing.
5. Discuss pain management as appropriate.
6. Emphasize post-procedure management and follow-up.

XRAY-S SAFETY

OUTCOME: Explain the procedure used to protect the patient and staff.

STANDARDS:

1. Discuss the use of personal protective equipment (i.e., lead shields, gloves) and their role in preventing transmission of disease or unnecessary radiation exposure.
2. Demonstrate the proper use of equipment to be used.
3. Discuss as appropriate that needles and other infusion equipment are single patient use and will be discarded.
4. Discuss the procedure for accidental needle-stick of the patient or the staff as appropriate.

XRAY-TE TESTS

OUTCOME: The patient/family will understand the test to be performed.

STANDARDS:

1. Explain the test that has been ordered.
2. Explain the necessity, benefits, and risks of the test to be performed. Refer to the primary provider as necessary.
3. Explain any necessary preparation for the test, i.e., fasting.
4. Explain the procedure for obtaining test results.

RSV—Respiratory Syncytial Virus

RSV-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and serious complications of RSV.

STANDARDS:

1. Discuss that many children with RSV also develop and ear infection (about 20% of the time).
2. Explain that only 1-2% of children with RSV will need hospitalization for oxygen or IV fluids.
3. Discuss that recurrent wheezing happens mostly in children who have close relatives with asthma. Some percentage of children who have RSV will go on to develop asthma.

RSV-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the disease process of RSV.

STANDARDS:

1. Explain that RSV is caused by a virus. Explain that viral illnesses are not made better by antibiotics.
2. Discuss that the virus causes a swelling of the smallest airways in the lungs (bronchioles). This narrowing results in wheezing and difficulty breathing. The wheezing and difficulty breathing typically gets worse for 2-3 days then begins to improve. The acute phase of the disease is usually 7-14 days long.
3. Discuss that recurrent wheezing happens mostly in children who have close relatives with asthma. Some percentage of children who have RSV will go on to develop asthma.
4. Explain that RSV is spread by droplets containing the virus. These droplets are usually created by the infected person coughing or sneezing them out. Infection usually occurs by touching the droplets then rubbing one's eyes or nose. Hand washing is the best way to prevent infection.
5. Discuss, as appropriate, that the worst disease happens in children less than 2 years of age. People older than this who become infected with RSV will usually experience severe cold-like symptoms.

RSV-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and strive to keep scheduled appointments.

STANDARDS:

1. Discuss the importance of keeping scheduled appointments to monitor the seriousness of the disease and prevention or treatment of complications.
2. Encourage full participation with the treatment plan. Assess the patient's understanding of the treatment plan and acceptance of the diagnosis.
3. Refer to PHN or community resources as appropriate.

RSV-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management plan and the importance of following the plan. Discuss the following standards as applicable to this patient.

STANDARDS:

1. Explain that dry air tends to make cough worse. Discuss the use of a humidifier to loosen secretions and soothe the airway.
2. Discuss the use of suction devices (such as bulb syringes) to remove sticky mucus from the nose and make breathing easier. Discuss the use of nasal saline drops to loosen the mucus.
3. Explain that warm liquids may be helpful to loosen secretions in the back of the throat and relieve coughing spasms. This may not be appropriate for very young infants.

RSV-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about RSV.

STANDARDS:

1. Provide the patient/family with written patient information literature on asthma.
2. Discuss the content of the patient information literature with the patient/family.

RSV-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and be able to demonstrate and explain the use of the prescribed medication regimen.

STANDARDS:

1. Review the patient's medication(s). Reinforce the importance of knowing the drug, dose, and dosing interval of medications.
2. Review common side effects, signs of toxicity, and drug interaction of medications(s).
3. Emphasize fully participating in the medication plan and explain how effective use of medications may reduce the risk of complications or hospital admission, as appropriate.

RSV-NEB NEBULIZER

OUTCOME: The patient/family will be able to demonstrate effective use of the nebulizer device, discuss proper care and cleaning of the system, and describe its place in the care plan.

STANDARDS:

1. Describe proper use of the nebulizer, including preparation of the inhalation mixture, inhalation technique (i.e., masks, blow-by), and care of the equipment.
2. Discuss the nebulizer treatment as it relates to the medication regimen.

RSV-P PREVENTION

OUTCOME: The patient/family will understand ways to help prevent RSV infection or spread of infection.

STANDARDS:

1. Explain that RSV is spread by contact with contaminated objects. Discuss the importance of hand washing and of disinfecting toys (especially in the day care setting).
2. Discuss the availability of passive immunization for RSV for selected groups of children, as appropriate. (Currently the recommendation for prophylaxis is children <24 months of age with bronchopulmonary dysplasia or with a history of premature birth (<32 weeks gestation). Refer to current literature for any updates on these recommendations.)

RSV-SHS SECOND-HAND SMOKE

OUTCOME: Provide the patient and/or family with an understanding of the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls.
2. Discuss harmful substances in smoke
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness in the RSV patient when exposed to cigarette smoke either directly or via second-hand smoke.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage smoking cessation or at least never smoking in the home or car.

RSV-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed.

STANDARDS:

1. Explain the test(s) ordered, i.e., nasopharyngeal wash or swab, pulsoximetry.
2. Explain the necessity, benefits and risks of the test(s) to be performed.
3. Explain how the testing relates to the course of treatment.

RSV-TO TOBACCO (SMOKING)

OUTCOME: The patient/family will understand the dangers of exposure of the patient with RSV to cigarette smoke and develop a plan to eliminate said exposure.

STANDARDS:

1. Explain the increased risk of hospitalization and serious or life threatening illness when a patient with RSV is exposed to cigarette smoke.
2. Explain that cigarette smoke gets trapped in carpets and upholstery and still increases the risk of illness even if the patient with RSV is not in the room at the time that the smoking occurs.
3. Encourage smoking cessation or at least NEVER smoking in the home or car.

S

SZ—Seizure Disorder

SZ-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications of the patient's seizure disorder.

STANDARDS:

1. Explain some of the complications that may occur during a seizure, i.e., anoxia from airway occlusion by the tongue or by vomitus, traumatic injury, potential for automobile accident.
2. Explain that uncontrolled seizures may result in progressive brain injury.

SZ-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

SZ-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of seizure disorders.

STANDARDS:

1. Explain that seizures are usually paroxysmal events associated with abnormal electrical discharges of the neurons of the brain.
2. Explain that at least 50% of seizure disorders are idiopathic. No cause can be found and the patient has no other neurologic abnormalities.
3. Discuss the patient's specific type of seizure disorder if known.
4. Explain that following a seizure it is usual for a patient to have a period of increased sleepiness (postictal phase).

SZ-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of regular follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of regular follow-up care in the prevention of complications and adjustment of medications.
2. Encourage full participation in the treatment plan. Discuss the patient/family responsibility in the management of seizure disorder.
3. Discuss the mechanism for obtaining follow-up appointments.

SZ-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about seizure disorders.

STANDARDS:

1. Provide the patient/family with written patient information literature about seizure disorders.
2. Discuss the content of the patient information literature with the patient/family.

SZ-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the impact of a seizure disorder on the patient/family's lifestyle and make a plan for needed adaptations.

STANDARDS:

1. Explain the importance of full participation with therapy to reduce seizure risk.
2. A normal lifestyle should be encouraged. Explain the particular risks of driving and participation in sports or other potentially hazardous activities if the seizure disorder is poorly controlled.
3. Emphasize a common sense attitude toward the patient's illness. Emphasis should be placed on independence and preventing invalidism.
4. Teach the patient's family how to care for the patient during a seizure, i.e.:
    a. Avoid restraining the patient during a seizure
    b. Help the patient to a lying position, loosen any tight clothing, and place something flat and soft such as a pillow under his/her head
    c. Clear the area of hard objects
    d. Avoid forcing anything into the patient's mouth
    e. Avoid using tongue blades or spoons as this may lacerate the patient's mouth, lips or tongue or displace teeth, and may precipitate respiratory distress.
    f. Turn the patient's head to the side to provide an open airway
    g. Reassure the patient after the seizure subsides, orienting him/her to time and place and informing him/her about the seizure.
5. Encourage the patient to get enough sleep as excessive fatigue may precipitate a seizure.
6. Discourage use of alcohol and street drugs as these may precipitate seizures.
7. Encourage the patient to learn to control stress, i.e., relaxation techniques.
8. Discuss the need to avoid photic stimulation such as strobe lights, emergency vehicle lights, light from some ceiling fans or any intermittent repeating light source.
9. Instruct that pregnancy or hormone replacement therapy may lower a person's seizure threshold.
10. Inform the family to keep track of duration, frequency and quality of seizure. Bring this log to the health care provider on follow-up.
11. Refer to community resources as appropriate.

SZ-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and be able to demonstrate and explain the use of prescribed medication.

STANDARDS:

1. Explain the importance of full participation with the prescribed medication schedule. Review the patient's medications. Reinforce the importance of knowing the drug dose and dosing intervals.
2. Review common and important side effects, signs of toxicity, and drug/drug, and drug/food interactions. Review signs of toxicity that should prompt immediate evaluation. Of note there is an interaction between most seizure medications and birth control pills that may make the contraceptive less reliable.
3. Explain the importance of having anticonvulsant blood levels checked at regular intervals even if seizures are under control as applicable.
4. Explain how consistent use of anticonvulsant medications as prescribed can facilitate a more active lifestyle by improved seizure control.
5. Emphasize the importance of notifying the health care provider if the patient is not taking the medication as prescribed.
6. Advise women of childbearing age to inform their health care provider prior to becoming pregnant or as soon as pregnancy is expected as many anticonvulsant medications may be teratogenic.

SZ-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand the necessary measures to undertake to avoid injury of the patient or others.

STANDARDS:

1. Teach the patient's family how to care for the patient during a seizure, i.e.:
   a. Avoid restraining the patient during a seizure
   b. Help the patient to a lying position, loosen any tight clothing, and place something flat and soft such as a pillow under his/her head.
   c. Clear the area of hard objects
   d. Avoid forcing anything into the patient's mouth
   e. Avoid using tongue blades or spoons as this may lacerate the patient's mouth, lips or tongue or displace teeth, and may precipitate respiratory distress.
   f. Turn the patient's head to the side to provide an open airway
   g. Reassure the patient after the seizure subsides, orienting him/her to time and place and informing him/her about the seizure.
2. Explain the particular risks of driving and participation in sports or other potentially hazardous activities if the seizure disorder is poorly controlled.

SZ-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in seizure disorders.

STANDARDS:

1. Explain that uncontrolled stress is linked with an increased frequency of seizures.
2. Explain that effective stress management may reduce the occurrence of seizures, as well as help improve the patient's health and well-being.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use, all of which can increase the risk of morbidity and mortality of seizure disorders.
4. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
5. Provide referrals as appropriate.

SZ-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

SARS—Severe Acute Respiratory Syndrome

SARS-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential consequences of exposure to and/or infection with the SARS virus.

STANDARDS:

1. Discuss with the patient/family the common or significant complications that may occur after infection with the SARS virus.
2. Discuss common or significant complications which may be prevented by full participation with the treatment regimen.
3. Discuss common or significant complications which may result from treatment(s).

SARS-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology, symptoms and prognosis of infection with the SARS virus.

STANDARDS:

1. Explain that SARS is a respiratory illness that is caused by a new virus, (called the SARS virus); the SARS virus is similar to the coronavirus, which is a frequent cause of the common cold. Explain that the SARS virus was discovered after February 1, 2003 so infections prior to this date are unlikely to have been diagnosed as SARS.
2. Explain that symptoms usually start two to seven days after exposure to SARS. Explain that the SARS virus may spread through face-to-face contact, airborne spread, contact with contaminated stool, or possibly environmental factors.
3. Discuss the current information regarding causative factors and pathophysiology of infection with the SARS virus.
4. Discuss the signs/symptoms and usual progression of SARS. Explain that infection with SARS begins with a fever of 100.5 degrees Fahrenheit or higher with or without rigors, which may be accompanied by other nonspecific symptoms such as fatigue, headache, and myalgias. After three to seven days, respiratory symptoms such as a nonproductive cough and dyspnea may begin. This may progress to respiratory failure and require artificial means of ventilation, i.e., intubation and/or mechanical ventilation.
5. Explain that some cases may be very severe and result in death while others may result in less severe cases similar to the common cold. Discuss that some groups, such as the elderly, persons with diabetes, pulmonary disease or other chronic illnesses, are at increased risk of severe disease.

SARS-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

SARS-HM HOME MANAGEMENT

OUTCOME - The patient/family will understand the necessity of home management of their disease as appropriate and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., prevention of the spread of the SARS virus. **Refer to SARS–LA**.
3. Explain the use and care of any necessary home medical equipment.

SARS-HY HYGIENE

OUTCOME: The patient will recognize good personal hygiene as an aspect of wellness.

STANDARDS:

1. Discuss the importance of personal hygiene to prevent the spread of the SARS virus.
2. Emphasize the importance of hand washing to prevent the spread of SARS.
3. Explain that utensils, towels, and bedding should not be shared without proper washing.

SARS-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the disease process or condition.

STANDARDS:

1. Provide patient/family with written patient information on the disease state or condition.
2. Discuss the content of patient information literature with the patient/family.

SARS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle adaptations that may be necessary to prevent the spread of the of the SARS virus to others or to improve physical health.

STANDARDS:

1. Discuss the importance of good hygiene and avoidance of high risk behaviors.
2. Discuss the current recommendations regarding quarantine or other methods to reduce the spread of SARS virus.
3. Review the community resources available to assist the patient in making lifestyle changes. Refer as appropriate.

SARS-M MEDICATIONS

OUTCOME - The patient/family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Explain that there are currently no medications (treatment or vaccine) to treat infection with the SARS virus. Some medications may help to alleviate the symptoms or prevent complications associated with the infection.
2. Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
3. Emphasize the importance of full participation with medication regimen.
4. Discuss the mechanism of action as needed.
5. Emphasize the importance of consulting with a health care provider prior to initiate any new medications, including over-the-counter medications.
6. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

SARS-P PREVENTION

OUTCOME - The patient/family will understand that healthy lifestyle behaviors can reduce the risk of developing diseases, conditions, or complications.

STANDARDS:

1. Discuss activities that decrease the risk for contracting the SARS virus such as avoidance of people exposed to the SARS virus or who have SARS and following CDC travel advisories. It is not known whether wearing a surgical mask prevents the spread or contracting of the SARS virus.
2. Discuss the importance of good hygiene and avoidance of high risk behavior.
3. Explain that the SARS virus can be contracted more than once.

SARS-TE TESTS

OUTCOME - The patient/family will understand the test(s) to be performed including indications and its impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
3. Explain any necessary preparation for the test, i.e., fasting.
4. Explain the meaning of test results.
5. Explain the implications of refusal of testing.

SARS-TX TREATMENT

OUTCOME - The patient/family will understand the possible treatments that may be available for SARS.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options.
2. Discuss the treatment plan including lifestyle adaptations, pharmacologic, surgical, and psychosocial aspects of the treatment plan.
3. Discuss the importance of adhering to the treatment plan, including scheduled follow-up.
4. Refer to community resources as appropriate.

STD—Sexually Transmitted Disease

Refer to **STI—Sexually Transmitted Infections**.

SWI—Skin and Wound Infections

SWI-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications associated with skin and wound infections.

STANDARDS:

1. Review with the patient/family the symptoms of a generalized infection, i.e., high fever spreading redness, red streaking, increased tenderness, changes in mental status, decreased urine output.
2. Review with the patient/family the effects of uncontrolled skin or wound infections (i.e., cellulitis) or generalized infection, i.e., loss of limb, need for facsiotomy and skin grafting, multi-organ failure, death.
3. Inform patient/family that scarring and/or tissue discoloration may develop after healing of the wound.
4. Emphasis the importance of early treatment to prevent complications.

SWI-DP DISEASE PROCESS

OUTCOME: The patient/family will understand cause and risk factors associated with skin and wound infections.

STANDARDS:

1. Review the current information regarding the causes and risk factors of skin and wound infections.
2. Explain how breaks in the skin can allow bacteria to enter the body.
3. Discuss importance of daily hygiene and skin inspection.
4. Explain that minor wounds should be kept clean and treated early to prevent serious skin or wound infections.
5. Explain, as appropriate, that the use of immunosuppressive or corticosteroid medication may increase the risk for skin and wound infections.
6. Explain, as appropriate, that elevated blood sugar increases the risk of serious skin and wound infections and impedes healing.
7. Review, as appropriate, peripheral vascular disease and/or ischemic ulcers as appropriate. **Refer to PVD.**
8. Discuss with the patient/family the pathophysiologic process of an inflammatory response.

SWI-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

SWI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointment.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that follow-up appointments should be kept.
4. Explain signs or symptoms that would prompt immediate follow-up, i.e., redness, purulent discharge, fever, increased swelling or pain.

SWI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about skin and wound infections.

STANDARDS:

1. Provide patient/family with written patient information literature.
2. Discuss the content of the patient information literature with the patient/family.

SWI-M MEDICATION

OUTCOME: The patient/family will understand the importance of full participation with the prescribed medication regimen.

STANDARDS:

1. Discuss reason for specific medication in treatment of this patient's infection.
2. Review directions for use and duration of therapy.
3. Discuss expected benefits of therapy as well as the important and common side effects. Discuss side effects that should prompt a return visit.
4. Discuss importance of full participation with medication regimen and how completion of an antibiotic course will help prevent the development of antibiotic resistance.
5. Emphasize the importance of follow-up.

SWI-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Discuss non-pharmacologic measures that may be helpful with pain control.

SWI-P PREVENTION

OUTCOME: The patient/family will understand the appropriate measures to prevent skin and wound infections.

STANDARDS:

1. Discuss avoidance of skin damage by wearing appropriate protective equipment (i.e., proper footwear, long sleeves, long pants, gloves), as appropriate.
2. Explain importance of good general hygiene and cleaning any breaks in the skin and observing for infections. **Refer to WL-HY**.
3. Review importance of maintaining good general health and controlling chronic medical conditions, especially glycemic control in diabetes. **Refer to DM-FTC.**

SWI-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

SWI-WC WOUND CARE

OUTCOME: The patient/family will understand the necessity and procedure for proper wound care and infection control measures. As appropriate they will demonstrate the necessary wound care techniques.

STANDARDS:

1. Explain the reasons to care appropriately for the wound, i.e., decreased infection rate, improved healing.
2. Explain the correct procedure for caring for this patient's wound.
3. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained
4. Emphasize the proper methods for disposal of used supplies.
5. Emphasize the importance of follow-up.
6. Discuss any special recommendations or instructions particular to the patient's wound.

ST—Strep Throat

ST-C COMPLICATIONS

OUTCOME: The patient/family will be able to relate the possible complications, the symptoms that should be reported immediately, and the appropriate actions to prevent complications.

STANDARDS:

1. Discuss the possible complications of untreated strep throat, i.e., rheumatic fever or glomerulonephritis.
2. List the symptoms that should be reported immediately, i.e., drooling, difficulty swallowing, blood in the urine, joint pains, abnormal movements and fever lasting longer than 48 hours after starting antibiotic.
3. Stress importance of follow-up appointment as appropriate.

ST-DP DISEASE PROCESS

OUTCOME: The patient will understand that strep throat may be a serious disease if left untreated.

STANDARDS:

1. Review ways in which strep throat can be spread to others in the family including family pets, i.e., eating or drinking after others, direct contact with secretions.
2. Explain that any child or adult in the home who has a fever, sore throat, runny nose, vomiting, and headache or develops these symptoms in the next five days should seek medical care.
3. Discuss that chronic or recurrent strep throat or rheumatic fever in a family member should prompt throat culture of all family members.
4. Discuss that strep throat is caused by a bacterium called *Streptococcus Pyogenes*. Explain that this bacterium may cause long term complications especially if untreated. **Refer to ST-C.**

ST-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of fully participating in the treatment regimen and keeping appointments for follow-up.

STANDARDS:

1. Discuss the patient's responsibility in the treatment of the strep throat.
2. Explain the procedure for making follow-up appointments.
3. Review the treatment plan with the patient/family, emphasizing the need for follow-up appointment and fully participating in the medication plan.

ST-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about strep throat.

STANDARDS:

1. Provide patient/family with written patient information literature on strep throat.
2. Discuss the content of patient information literature with the patient/family.

ST-M MEDICATIONS

OUTCOME: The patient will understand the importance of following the prescribed medication regimen.

STANDARDS:

1. Review proper use, benefit and common side effects of the prescribed medication.
2. Emphasize the importance of maintaining full participation in the medication regiment, i.e., take all the medication even if the symptoms are no longer present.
3. Explain that failure to complete the entire course of antibiotics increases the patient's risk of developing rheumatic heart disease and rheumatic fever as well as the risk of developing resistant bacteria.

ST-P PREVENTION

OUTCOME: The patient/family will understand the measures necessary to prevent the spread of strep throat.

STANDARDS:

1. Explain the importance of good hygiene and infection control principles to prevent the spread of strep infection.
2. Stress the importance of good hand washing.

ST-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand some ways to control pain associated with strep throat.

STANDARDS:

1. Discuss pain management techniques with the patient/family, i.e., gargling salt water, throat lozenges, and other medications as appropriate.

ST-TE TESTS

OUTCOME: The patient will understand the test to be performed and the reason for testing.

STANDARDS:

1. Explain the test used to diagnose strep throat, i.e., throat culture or rapid strep test.
2. Explain the indications and benefits of the test.
3. Explain the test as it relates to the diagnosis and treatment of strep throat.

SIDS—Sudden Infant Death Syndrome

SIDS-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

SIDS-I INFORMATION

OUTCOME: Parents/Family will understand what SIDS is and factors that are associated with increased risk of SIDS.

STANDARDS:

1. Explain that SIDS stands for Sudden Infant Death Syndrome. It is the sudden and unexplained death of a baby under 1 year of age. Most SIDS deaths happen between 2 and 4 months of age, occur during colder months, and more likely to be boys than girls.
2. Explain that because many SIDS babies are found in their cribs, some people call SIDS "crib death." But, cribs do not cause SIDS.
3. Explain that the cause of SIDS remains unknown. SIDS is unique, because, by definition its major presenting symptom is unexplained death. The diagnosis is based entirely on what is not found. SIDS is, in other words, a diagnosis of exclusion.
4. Emphasize that although the incidence of SIDS is on the decline in the US, the rate of SIDS highest among Native Americans and Alaska Natives.
5. Explain that several important factors are associated with an increased risk of SIDS. These factors are prone (stomach) and side infant sleeping positions, exposure of infants to cigarette smoke and potentially hazardous sleeping environments.

SIDS-L PATIENT INFORMATION LITERATURE

OUTCOME: The parent(s) and family will receive written information about Sudden Infant Death Syndrome.

STANDARDS:

1. Provide the parent(s) and family with written information about SIDS.
2. Discuss the content of the patient information literature with the parent(s) and family.

SIDS-P PREVENTION

OUTCOME: The parents and/or family will understand the factors associated with an increased risk of SIDS and how to lower the risk of SIDS and prevent problems.

STANDARDS

1. Explain that placing your baby on his or her back to sleep, even for naps, is the safest sleep position for a healthy baby and has been proven to reduce the risk of SIDS. "Back is best" from a SIDS risk-reduction point of view. There is no evidence of increased risk of choking or other problems associated with healthy infants sleeping on their backs.
2. Explain that the stomach sleeping position is associated with the highest risk of SIDS. Side lying position falls in between and babies who sleep on their sides can roll onto their stomach and have an increased risk of SIDS.
3. Explain that when a baby sleeps only in the back position, some flattening of the back of the head may occur. Flat spots on the back of the head are not harmful or associated with any permanent effects on head size and go away a few months after the baby learns to sit up.
4. Discuss that specialists recommend changing the baby's head position during sleep to minimize the effects on head shape. One way to do this is to alternate the head of the bed to the foot of the bed on alternate nights. That is, place the baby's head on different ends of the bed on different nights with the face always facing the inside of the room.
5. Explain that "tummy time" is important. An infant can safely be placed on his or her tummy when he/she is awake and someone is watching. This is important for infant development and will help make neck and shoulder muscles stronger.
6. Explain that there is no evidence that infant home monitoring can prevent SIDS. Physicians may recommend monitors in some special circumstances.
7. Discuss that the greatest majority of infants dying of SIDS are apparently healthy infants who do not meet the criteria for home monitoring.
8. Discuss that other sleep behaviors are associated with a higher than average rate of SIDS deaths; (co-sleeping, fluffy materials in the bed with the infant, waterbed sleeping, sleeping in the same bed with other persons, overheating during sleep.
9. Discuss that alcohol use in the first trimester of pregnancy is associated with increased risk of SIDS death.
10. Explain that infants who sleep in homes where smoking occurs inside the home are at a greatly increased risk of dying of SIDS compared to infants who sleep in homes where no one ever smokes in the home.
11. Encourage the client to be receptive to home visits by public health nurses as this has been associated with a lower risk of SIDS deaths.

SIDS-S SAFETY AND INJURY PREVENTION

OUTCOME: The parents/family will understand that even though there is no way to know which babies might die of SIDS, there are some measures that can be taken to make their baby safer.

STANDARDS:

1. Discuss that placing a baby to sleep on soft mattresses, sofa cushions, waterbeds, sheepskins, or other soft surfaces can increase the risk of SIDS, possibly by increasing the risk of carbon dioxide rebreathing (asphyxiation).
2. Emphasize firm bedding, Discourage the use of pillows, loose bedding, crib bumpers, fluffy blankets and stuffed toys in the baby's sleep area. Make sure baby's face and head stays uncovered during sleep.
3. Discuss potential hazards of overheating. Don't let baby get too warm during sleep. Babies should be lightly dressed and covered with a sheet or thin blanket, and the room temperature should be comfortable. The current recommendation is for no more than two layers of clothing during sleep.
4. Discuss that there are hidden hazards in letting babies sleep on adult beds, including falls, suffocation, and getting trapped between the bed and wall, the head board, and foot board. Beds are not designed to meet safety standards for infants and carry risk of accidental entrapment and suffocation.
5. Explain that it is currently believed that the safest place for an infant to sleep is in a crib with a firm mattress. Sleeping alone, with no other person in the bed is recommended. Infants sleeping in adult beds are at increase risk of suffocation.

SIDS-SHS SECOND-HAND SMOKE

OUTCOME: The patient and/or family will understand the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting babies' exposure to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. smoldering cigarette, cigar or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets, or walls.
2. Discuss harmful substances in smoke
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances).
3. Discuss that tobacco smoke increases the risk of SIDS and it appears to be related to the "dose" of passive-smoke exposure - - the greater the exposure to smoke both before and after birth, the higher the risk of SIDS.
4. Explain that smoking anywhere in the home may increase the risk, so just going into another room to smoke is not sufficient. Smoke gets trapped in carpets, upholstery, and clothing. Parents should keep the baby in a smoke-free environment.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage and offer smoking cessation or at least never smoking in the home or car.
7. **Refer to TO**.

SB—Suicidal Behavior

SB-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

SB-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

SB-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about suicidal behavior.

STANDARDS:

1. Provide the patient/family with written patient information literature on suicidal behavior.
2. Discuss the content of patient information literature with the patient/family.

SB-PSY PSYCHOTHERAPY

OUTCOME: The patient will understand the goals and process of such therapy.

STANDARDS:

1. Emphasize that for the process of psychotherapy to be effective the patient must keep all appointments. Emphasize the importance of openness and honesty with the therapist.
2. Explain to the patient/family that the therapist and the patient will jointly establish goals, ground rules, and duration of therapy.

SB-SCR SCREENING

OUTCOME: The patient/family will understand the screening device.

STANDARDS

1. Explain the screening device to be used.
2. Explain why the screening is being performed.
3. Discuss how the results of the screening will be used.
4. Emphasize the importance of follow-up care.

SB-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in suicidal behaviors.

STANDARDS:

1. Explain that uncontrolled stress is linked with the onset of major depression and contributes to more severe symptoms of depression.
2. Explain that uncontrolled stress can interfere with the treatment of suicidal behaviors.
3. Explain that effective stress management may reduce the severity of symptoms the patient experiences, as well as help improve the health and well-being of the patient.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all of which can increase the severity of the depression and increase risk of suicidal behaviors.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

SB-TX TREATMENT

OUTCOME: The patient/family will have a basic understanding of the short and long term goals and expected result of treatment.

STANDARDS:

1. Reassure the patient. Reinforce the fact that the patient is not alone and that he/she can be helped.
2. Discuss options for treatment, both short-term and long-term.
3. Discuss that there may be an initial crisis stabilization period followed by a longer period of psychotherapy and lifestyle adjustments.

SB-WL WELLNESS

OUTCOME: The patient/family will understand some of the factors which contribute to a balanced and healthy lifestyle.

STANDARDS:

1. Explain that a healthy diet is an important component of behavioral and emotional health. **Refer to WL-N.**
2. Emphasize the importance of stress reduction and exercise in behavioral and emotional health.
3. Explain that behavior and emotional problems often result from unhealthy patterns of social interaction. Help to identify supportive social networks.
4. Emphasize that use of alcohol and/or other drugs of abuse can be extremely harmful to behavioral and emotional health. **Refer to AOD.**
5. Emphasize that behavioral and emotional problems often co-exist with domestic violence. Encourage the patient to use local resources as appropriate. **Refer to DV.**
6. Explain other ways the patient can help him/herself feel better:
   a. Talk to someone you trust.
   b. Try to figure out the cause of your worries.
   c. Understanding your feelings will help you see other ways for dealing with your anger or depression.
   d. Write down a list of good things you have done. Remember them and even read the list out loud to yourself when you feel bad.
   e. Do not keep to yourself; being with other people that support and encourage you as much as possible.
   f. **In an emergency or during a crisis call 9-1-1** or other emergency access numbers or crisis hotlines.

SUN—Sun Exposure

SUN-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications associated with excessive sun exposure.

STANDARDS

1. Explain that UVB causes sunburn and plays a significant role in superficial skin cancers called basal cell carcinomas and squamous cell carcinomas.
2. Discuss the 4 ABCD warning signs of malignant melanoma:
    a. Asymmetry – one half of the mole or lesion differs from the other half
    b. Border – The border of the mole or lesion is irregular, scalloped or underlined
    c. Color – Color varies from one area to another within the mole or lesion
    d. Diameter – The mole or lesion is larger than 6mm across – about the size of a pencil eraser
3. Explain that sunburns before the age of 18 are more likely to cause skin cancers later on in life.
4. Explain that excessive sun exposure causes premature aging of the skin.
5. Explain that dehydration and pain are common complications of sunburn.
6. Explain that secondary infections may result from sunburns that blister and peel.

SUN-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of overexposure to the sun or other UV radiation/light.

STANDARDS:

1. Explain that the two types of ultraviolet radiation – ultraviolet A (UVA) and ultraviolet B (UVB) – have an effect on your skin and can impair your skin's DNA repair system which may contribute to cancer.
2. Explain that UVA usually causes the leathery, sagging, brown-spotted skin of those who spend a lot of time in the sun. UVA can also penetrate window glass, including car windows. Tanning beds are a source of high doses of UVA.
3. Explain that sunburn is the result of overexposure to the sun's ultraviolet (UV) radiation. Repeated exposure to UV radiation both tans and damages your skin. The signs and symptoms of sunburn usually appear within a few hours of exposure, bringing pain, redness, swelling and occasional blistering. Because sun burn often affects a large area of your skin, sunburn can cause headache, fever and fatigue.
4. Explain that the first step is to determine the degree and the extent of damage to body tissues. Damage from the sun is usually limited to first and second degree burns:
    a. First-degree burns are those in which only the outer layer of skin (epidermis) is burned. The skin is usually red, with swelling and pain sometimes present. The outer layer of skin hasn't been burned through. Treat a first degree burn as a minor burn unless it involves substantial portions of the hands, feet, face, or other large areas of the body.
    b. Second-degree burns are when the first layer of skin has been burned through and the second layer of skin (dermis) also is burned. Blisters develop and the skin takes on an intensely reddened, splotchy appearance. Second-degree burns produce severe pain and swelling.

SUN-I INFORMATION

OUTCOME: Parents/Family will understand sunburns; and the factors that are associated with increased risk of sunburn.

STANDARDS:

1. Explain that the UV content of sunlight varies. It's greater at higher elevations because it is unfiltered by clouds or haze. But reflected UV light also comes from snow, sand, water and other highly reflective surfaces and can burn as severely as direct sunlight. You can also get sunburn on a cloudy day
2. Explain that protection from the sun is very important in the prevention of skin cancer. Protective steps should begin in early childhood. Regular, proper use of broad-spectrum sunscreens such as those that offer protection from both UVA and UVB radiation is the key in preventing sunburn, sun damage and skin cancer.
3. Explain that regardless of skin pigmentation, all people are at risk for sun damage to their skin and should wear sunscreen.

SUN-L PATIENT INFORMATION LITERATURE

OUTCOME: The parent(s) and family will receive written information appropriate to the type and degree of the sunburn.

STANDARDS:

1. Provide written information about first and second-degree burns that are the result of over-exposure to the sun.
2. Discuss the content of the patient information literature.

SUN-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle adaptations necessary to prevent complications of sunburn.

STANDARDS:

1. Review lifestyle aspects/changes that the patient has control over, such as:
    a. Consistent use of a sunscreen each and every day
    b. Discuss the importance of infants, children and youth using a sunscreen. Explain that sunburns before the age of 18 are more likely to cause skin cancers later on in life.
    c. Avoid the use of tanning beds
    d. Limit outdoor exposure to early morning or late afternoon. Sunlight is strongest from 11am-2pm.
    e. Wear appropriate clothing to cover the body, i.e., long sleeved shirts and wide brimmed hats.

SUN-P PREVENTION

OUTCOME: The patient/family will understand the factors associated with an increased risk of sunburns and how to lower the risk of sunburn and prevent complications.

STANDARDS

1. Explain that protection from the sun is very important in the prevention of skin cancer. Protective steps should begin in early childhood. Regular, proper use of broad-spectrum sunscreens such as those that offer protection from both UVA and UVB radiation is the key in preventing sunburn, sun damage and skin cancer.
2. Explain that when purchasing sunscreens, it is important to check the label to ensure that the product is a broad spectrum sunscreen offering both UVA and UVB protection. Sunscreen advertisements such as total sunblock, waterproof, all-day protection and deep-tanning are mis-leading as they do not necessarily offer both UVA and UVB protection. Read sunscreen labels carefully for UVA and UVB protection.
3. Explain that the Sun Protection Factor (SPF) ratings are based on how much longer someone may be protected from sunburn than he or she is if no sunscreen were applied. For example, if you normally burn in 20 minutes, a product with SPF 15 may allow you to stay out in the sun 15 times longer, if properly applied. The minimum level of SPF purchased should be SPF 15.
4. Explain that most people use sunscreens too sparingly. A liberal application is 1 ounce – two tablespoons full – to cover exposed parts of the body.
5. Explain that the timing of sunscreen application is also important. To have the best effect, sunscreens need to be applied 30 minutes before any outdoor activities– not after you go out.
6. Explain that because of sweating, swimming and toweling off, sunscreen should be reapplied throughout the day. Even water-resistant sunscreens need to be reapplied every 90 minutes.
7. Discuss the need to avoid using tanning beds. There is no such thing as a safe tan. Tanning beds aren't safe, and they may cause skin cancer. While tanning salons may advertise that they use only UVA light, research doesn't support VUA being "good" and UVB – as being "bad." Both UVA and UVB may increase the risk of skin cancer or melanoma.
8. Explain that if a tan is desired, consider use of one of the many "bronzers" available at cosmetic counters. Patients using "bronzers" must be reminded that they must still use a sunscreen over their "bronzer" as bronzers usually do not contain sunscreens.
9. Discuss ways in which the patient can protect themselves from the sun regardless of whether you are in the sun for work or play.
10. Explain that regardless of skin pigmentation, all people are at risk for sun damage to their skin and should wear sunscreen.

SUN-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient will understand that precautions should be taken every day to avoid over exposure to UVA and UVB sunlight.

STANDARDS:

1. Discuss the consistent use of a sunscreen each and every day.
2. Discuss the added importance of infants, children and youth using a sunscreen.
3. Remind patient/family to avoid the use of tanning beds.
4. Emphasize outdoor exposure during the 11am-2pm time period should be limited.

SUN-TX TREATMENT

OUTCOME: The patient/family will understand the importance of treating the discomforts of sunburn and when to seek appropriate medical care.

STANDARDS:

1. Explain that exposure to large areas of the skin can result in headache, fever, fatigue, and dehydration.
2. Explain that if you have a sunburn:
   a. Take a cool bath or shower
   b. Apply an aloe vera lotion several times a day
   c. Leave blisters intact to speed healing and avoid infection. If they burst, apply an antibacterial ointment on the open areas and cover with a sterile gauze bandage.
3. Explain, if needed, for discomfort take a mild over-the-counter analgesic.
4. Encourage consumption of water or other non-caffeinated beverages.
5. Explain that severe sunburn may require and benefit from medical attention.
6. Encourage the patient to be smart about sun exposure:
   a. wear a broad-brimmed hat and light-colored clothing that covers your exposed skin
   b. use a broad-spectrum sunscreen
   c. limit outdoor sports and other activities to the early morning or late afternoon whenever possible.
   d. wear UVA and UVB rated sunglasses
7. Explain that the use of alcohol and other drugs may impair sound judgment when participating in outdoor activities. Caution should be exercised in combining the use of alcohol and other drugs with outdoor activities.
8. Refer to **BURN**.

T

TO—Tobacco Use

It is important to screen tobacco use and to record the responses appropriately in the Health Factors. Listed below are the definitions for tobacco use:

- Non-Tobacco Use – *Never* used *any* tobacco products
- Current Smoker – Smokes. Ask number of cigarettes/packs smoked per day
- Current Smokeless – Uses smokeless. Ask number of Cans/plugs per day
- Cessation Smoker – Former smoker, now quit. Document Quit Date _____
- Cessation Smokeless – Former smokeless user, now quit. Document Quit date____
- Previous Smoker – Smoker who smoked for ____years. Now Quit.
- Previous Smokeless – Smokeless user for ___ years. Now Quit.
- Non-Smoker but smoker in home, i.e., exposed to second hand smoke
- Environmental Exposure – Works in environment (casino, Bingo) with exposure to smoke.
- Ceremonial/Traditional use of tobacco

TO-C COMPLICATIONS

OUTCOME: The patient/family will understand how to avoid the slow progression of disease and disability resulting from tobacco use.

STANDARDS:

1. Discuss the common problems associated with tobacco use and the long term effects of continued use of tobacco, i.e., COPD, cardiovascular disease, numerous kinds of cancers including lung cancer.
2. Review the effects of tobacco use on all family members- financial burden, second-hand smoke, asthma, greater risk of fire, early death of a bread-winner.
3. Discuss the possible implications of tobacco use on newborns, infants and children, as well as being a possible link to SIDS.

TO-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

TO-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the slow progression of disease and disability associated with tobacco use.

STANDARDS:

1. Review the current factual information regarding tobacco use. Explain that tobacco use in any form is dangerous.
2. Explain nicotine addiction.
3. Explain dependency and co-dependency.

TO-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in this patient's disease process and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
2. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
3. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
4. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
5. Discuss medical clearance issues for physical activity.

TO-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

TO-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about tobacco use or cessation of use.

STANDARDS:

1. Provide the patient/family with written patient information literature on tobacco use or cessation of use.
2. Discuss the content of the patient information literature with the patient/family.

TO-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will see tobacco abstinence as a way of life.

STANDARDS:

1. Discuss the patient's use/abuse of tobacco.
2. Discuss tips for stress relief and healthy "replacement habits".
3. Discuss the difference between recreational use of tobacco versus traditional or ceremonial use of tobacco.

TO-M MEDICATIONS

OUTCOME: If applicable, the patient/family will understand the importance of fully participating with a prescribed medication regimen.

STANDARDS:

1. Review the proper use, benefits and common side effects of the prescribed medication.
2. Briefly review the mechanism of action of the medication if appropriate.
3. Explain that medications can help only if the patient is ready to quit and that medications work best in conjunction with counseling and lifestyle-modification education.
4. Explain that some medications may not work right away but will require a few days to a few weeks to take effect.
5. Emphasize that there may be dangers in using medications in conjunction with smoking and that some medications may be addictive, so it is important to have a dose-tapering regimen and keep to it.

TO-QT QUIT

OUTCOME: The patient/family will understand that smoking is a serious threat to their health, that they have been advised by health professionals to quit, and how participation in a support program may prevent relapse.

STANDARDS:

1. Discuss the importance of quitting tobacco use now and completely.
2. Establish a quit date and plan of care.
3. Review the treatment and support options available to the patient/family.
4. Review the value of close F/U and support during the first months of cessation.

TO-RTC READINESS TO CHANGE

OUTCOME: The patient/family will understand

STANDARDS

RTC 1 The patient has no interest in making the recommended change. Precontemplation (Ready in more than 6mos)

RTC 2 The patient has begun to show interest in making the recommended change. Contemplation (Ready in 1-6 mo)

RTC 3 The patient is beginning to make preparations to make the change. Preparation (Ready in 30 days or less)

RTC 4 The patient is actively making a change. Action (Quitting 0-6mo)

RTC 5 The patient has continued to Maintenance (quit for at least 6 months or more)

TO-SCR SCREENING

OUTCOME: The patient/family will understand the screening device.

STANDARDS

1. Explain why the screening is being performed.
2. Discuss how the results of the screening will be used.
3. Emphasize the importance of follow-up care.

TO-SHS SECOND-HAND SMOKE

OUTCOME: Provide the patient and/or family with an understanding of the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls.
2. Discuss harmful substances in smoke
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness in people who are exposed to cigarette smoke either directly or via second-hand smoke. Explain that this risk is even higher for people with pulmonary diseases like COPD or asthma.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Discuss not smoking around infants and children, including in the home and in the car. Second hand smoke increases the risk of SIDS. Encourage smoking cessation.

TO-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in tobacco abuse and its effect on tobacco cessation.

STANDARDS:

1. Discuss that uncontrolled stress may increase tobacco use and interfere with tobacco cessation.
2. Explain that uncontrolled stress can interfere with the treatment of tobacco addiction.
3. Discuss that uncontrolled stress may exacerbate adverse health behaviors such as increased alcohol or other substance use, all of which can increase tobacco use and interfere with tobacco cessation.
4. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
5. Provide referrals as appropriate.

U

URI—Upper Respiratory Infection

URI-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

URI-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of an upper respiratory tract infection.

STANDARDS:

1. Explain that URIs (colds) are caused by viruses and that antibiotics are not effective.
2. Discuss the basic anatomy of the upper respiratory system.
3. Discuss the factors that increase the risk for acquiring an upper respiratory infection, i.e., direct physical contact, children in school.
4. Discuss signs and symptoms of an upper respiratory infection, i.e., malaise, rhinorrhea, sneezing, scratchy throat.

URI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up if needed.

STANDARDS:

1. Discuss the importance of follow-up care, if needed. Explain that follow-up is usually only necessary if symptoms persist for greater than 2 weeks or if symptoms worsen.
2. Discuss the process for obtaining follow-up care and or appointment.
3. Emphasize that appointments should be kept.

URI-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand how to manage an upper respiratory infection at home.

STANDARDS:

1. Discuss the use of over the counter medications for symptom relief, i.e., decongestants, antihistamines, expectorants.
2. Discuss the use of non-pharmacologic therapies that may be useful in symptom relief, i.e., nasal lavage, humidification of room, increasing oral fluids.

URI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about upper respiratory infections.

STANDARDS:

1. Provide patient/family with written patient information literature on upper respiratory infection.
2. Discuss the content of patient information literature with the patient/family.

URI-M MEDICATIONS

OUTCOME: The patient/family will understand that antibiotics do not cure viral infections, and understand that some over-the-counter medications may be helpful in symptom reduction.

STANDARDS:

1. Discuss the use of over the counter medications, vitamin supplements and herbal remedies for symptom relief, i.e., decongestants, antihistamines, expectorants.
2. Explain that URIs (colds) are caused by viruses and that antibiotics are not effective.

URI-P PREVENTION

OUTCOME: The patient/family will have an understanding how to reduce the transmission of the common cold.

STANDARDS:

1. Discuss infection control measures, i.e., hand washing, reducing finger-to-nose contact, limiting exposure to the cold sufferer, proper handling and/or disposal of contaminated items.

UTI—Urinary Tract Infection

UTI-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand basic anatomy and physiology as it relates to UTIs.

STANDARDS:

1. Discuss the basic anatomy and physiology of the urinary tract as it relates to UTIs. As appropriate, discuss the difference between male and female anatomy.
2. As appropriate, discuss the role of foreskin in recurrent UTIs.

UTI-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of a urinary tract infection.

STANDARDS:

1. Discuss the basic anatomy and physiology of the urinary tract.
2. Discuss factors that increase the risk for developing a urinary tract infection, i.e., bladder outlet obstruction, hygiene factors, pelvic relaxation.
3. Discuss some signs and symptoms of urinary tract infection, i.e., dysuria, frequency, nocturia.

UTI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care, including test of cure as appropriate.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

UTI-HY HYGIENE

OUTCOME: The patient/family will understand how personal hygiene affects acquiring UTIs and prevention of UTIs.

STANDARDS:

1. Review the aspects of good personal hygiene as it relates to prevention of UTIs:
   a. Wipe only from anterior to posterior (front to back).
   b. Avoid bubble baths.
   c. Keep the perineal region clean.
2. Discuss the role of foreskin hygiene as appropriate.
3. Discuss, as appropriate, the role of sexual intercourse in acquiring UTIs.

UTI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about urinary tract infections.

STANDARDS:

1. Provide patient/family with written patient information literature.
2. Discuss the content of the patient information literature with the patient/family.

UTI-M MEDICATION

OUTCOME: The patient/family will understand their medication regimen and the importance of full participation with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications. **Refer to M**.
3. Discuss importance of full participation with the medication regimen in order to promote healing and assure optimal comfort levels.
4. Discuss the importance of completing the entire course of antibiotics to decrease the risk of development of resistant organisms.
5. Inform patient/family that kidney damage is irreversible and special care needs to be taken to reduce the risk of recurrent infections.

UTI-N NUTRITION

OUTCOME: The patient/family will understand the importance of a nutritionally balanced diet as related to UTIs.

STANDARDS:

1. Assess current nutritional habits and needs.
2. Emphasize the necessary component - WATER - in a healthy diet. Decrease consumption of colas and caffeinated beverages.

UTI-P PREVENTION

OUTCOME: The patient/family will understand precipitating factors for UTIs and will make a plan to minimize recurrence.

STANDARDS:

1. Discuss importance of fully participating in treatment plan.
2. Discuss the role of good hygiene in reducing the risk of UTIs.
3. Discuss the role of prophylactic medications in reduction of future UTIs as indicated.
4. Discuss other lifestyle factors that may help prevent UTIs, i.e., frequent urination, void after sexual intercourse, monogamy, drink plenty of water, eliminate bubble baths.

UTI-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM.**
2. Explain that medications may be helpful to control the symptoms of pain, nausea and vomiting as applicable.
3. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
4. Explain non-pharmacologic measures that may be helpful with pain control.

UTI-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in sexually transmitted infections.

STANDARDS:

1. Explain that uncontrolled stress is linked with an increased recurrence of symptomatic outbreaks with many sexually transmitted infections, such as genital herpes and human papilloma virus.
2. Explain that effective stress management may help reduce the frequency of outbreaks, as well as help improve the patient's health and well-being.
3. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals in small attainable increments
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation or prayer
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
4. Provide referrals as appropriate.

UTI-TE TESTS

OUTCOME: The patient/family will have basic understanding of the tests to be performed including indications, risks, benefits and consequences of non-intervention.

STANDARDS:

1. Explain the test ordered including indication(s), risks, benefits, information to be obtained and consequences of non-intervention.
2. Explain that the treatment decision will be made by the patient and medical team after reviewing the results of the diagnostic tests.
3. Explain any preparation that must be done prior to testing, i.e., NPO, have a full bladder, void prior to test.