INDIAN HEALTH SERVICE

Patient and Family Education Protocols and Codes (PEPC)

12th Edition
June 2006

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 the Clinical Reporting System (CRS) and GPRA as indicators.

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. Many years ago, nurses in the Tucson Area, led by Elizabeth Dickey, R.N. developed the first brief manual envisioning an easier way to document education in the Indian Health Service. A special thanks to Shirley Teter, OIT, for her assistance in formatting and ensuring consistency in our document. We would like to thank all the I/T/U programs 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 disk, in Word or Word Perfect format. Please try to follow the existing format as much as possible and as much as possible use mnemonics (codes) that are already in existence. The submissions will be reviewed by the committee and may be changed extensively prior to their publication for general use. New submissions should be sent to:

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Co-Chairs, National Patient Education Protocols Committee

FOREWARD TO THE 12th EDITION OF THE PATIENT EDUCATION PROTOCOLS

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Important Changes in the 12th Edition

CHEMICAL DEPENDENCY CHANGE: The mnemonic CD for Chemical Dependency has been changed to AOD - Alcohol and Other Drugs. The change from the mnemonic CD to AOD was at the request of the Behavioral Health Program. Questions/concerns about this change should be addressed to Jon Perez, Director, IHS Behavioral Heath Program or Denise Grenier, OIT BH representative. For the short-term, "CD" will remain a viable mnemonic but will eventually become obsolete in RPMS and totally replaced by AOD. We suggest you begin using the new AOD term now.

CULTURAL/SPIRITUAL ASPECTS Of HEALTH (CUL): CUL is a major new addition to the 2006 Protocols and Codes to document education/counseling that reflects an integration of the impact and influences that cultural and spiritual traditions, practices, and beliefs have on health and wellness.

MEDICAL NUTRITION THERAPY (MNT): MNT has been added to many of the Protocols and Codes. Only Registered Dietitians are permitted to use the MNT code. Questions concerning the MNT protocols and codes should be directed to Cecilia Butler, RD, Santa Fe Service Unit.

WELLNESS CHANGE: The mnemonic WL has been changed to HPDP - Health Promotion Disease Prevention. This change was made to keep our protocols and codes in line with GPRA and the Director's Performance Contract. Questions concerning HPDP protocols and codes should be directed to Mary Wachacha.

GRIEF: GRIEF is a new addition to the 2006 Protocols and Codes. Grief is often associated with losses other than "end of life." The patient education topic "GRIEF" was added to address the education provided to patients who are grieving because of other losses. These losses may include a home, a spouse through divorce, a job, or even a favorite pet. The s are general so they can be adapted to a wide variety of situations.

LITERATURE: The title for literature given to the patient was previously Patient Education Literature. It has been changed to Literature. This change will allow users to more easily find this topic as it will now be "filed" under "L" instead of "P."

CASE MANAGEMENT (CM): The title previously associated with the mnemonic CM was Care Management. The committee felt that the more appropriate term would be Case Management. The title for CM has been changed throughout the manual to Case Management.

RHEUMATIC DISEASE CHANGE: The PEP-C previously contained a topic and mnemonic called Rheumatic Disease (RD). This will be inactivated and the new topic/mnemonic is RA - Rheumatic Arthritis. We have plans to develop protocols for Ostoarthritis and Juvenile Rheumatoid Arthritis. Most other "Rheumatic Diseases" can be covered with the mnemonic ATO -autoimmune Disorders.

In June of 2006, many protocols were revised to include more sub-topics and/or fewer s. Please discard old manuals and assure that your local Information Technology Department /Computer Department has installed all current patches for RPMS.

Use and Documentation of Patient Education Codes

Why Use the Codes?

Hospital or clinic policies and procedures must clearly indicate that the facility will use the *IHS Patient Education Protocols and Codes (PEPC) Manual*. A copy of the entire PEPC Manual must be located within the hospital/clinic policies and procedures.

Use of the codes helps nurses, physicians, and other healthcare providers to document and track patient education. While it is desirable to spend 15, 30, even 60 minutes making an assessment of educational needs, provide the education and then document 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 entered into RPMS and RPMS transfers that information not only to the National Patient Information Resource System (NIPRS) but the information is also transferred to the individual patient health summary. The information located on the patient's chart informs everyone using the patient's chart that a given patient received education on specific topics. Use of the codes reflects that a minimum of education (i.e., the protocols) were provided to the patient.

The codes are limited in that they do not detail the exact nature of the education – locally developed lesson plans should reflect *exactly* what was taught – but locally developed lesson plans must be built upon the protocols contained in the Manual. Use of the protocols for patient education does not preclude the development and use of lesson plans. Good education requires that lessons plans be developed that are built upon the foundation of the protocols. The codes are merely an abbreviated tool used to document the comprehensive education that was provided. 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:

07/19/05 DM-Nutrition, poor understanding, 10 min. (Provider Initials) GS: Pt. will include 5 veg/fruit/day
10/27/05 DM-Foot care, good understanding, 7 min. (Provider Initials)GM: Pt included 5 veg/fruit/day
11/07/05 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 the patient's diabetes.

Charting and the Codes

Use of the codes *does not* preclude or require writing a 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 the SOAP note and use the codes 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 PCC forms on the following pages illustrate appropriate documentation of patient education.

Recording the Patient's Response to Education

The patient's response to education is the patient's reported level of understanding. One way of accessing the understanding is the teach-back method. (Teach-back is the patient's ability to restate what was taught.) The patient's level of understanding should be assessed in conjunction with barrier to learning, readiness to learn, and learning preferences. The following "Levels of Understanding" must be used:

Good (**G**):	Verbalizes understanding Able to return demonstration or teach-back correctly
Fair (**F**):	Verbalizes need for more education Incomplete return demonstration or teach-back indicates partial understanding
Poor (**P**)	Does not verbalize understanding Unable to return demonstration or teach-back
Refuse (**R**):	Refuses education
Group (**Gp**):	Education provided in group. Unable to evaluate individual response

Documenting Patient Education (Forms)

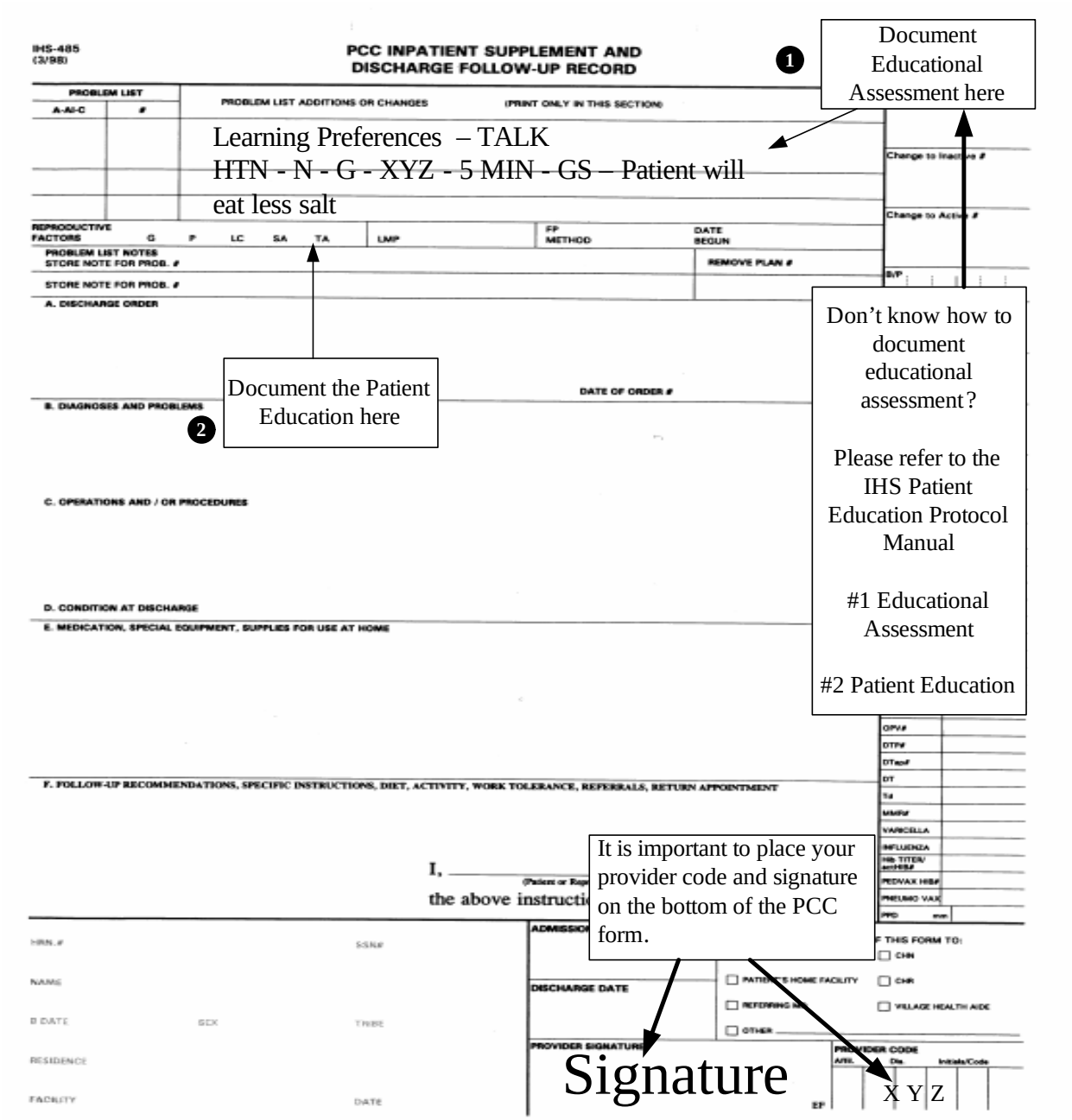


Figure 1: ***Documenting Patient Education on the PCC Inpatient Supplement and Discharge Follow-Up Record form.***

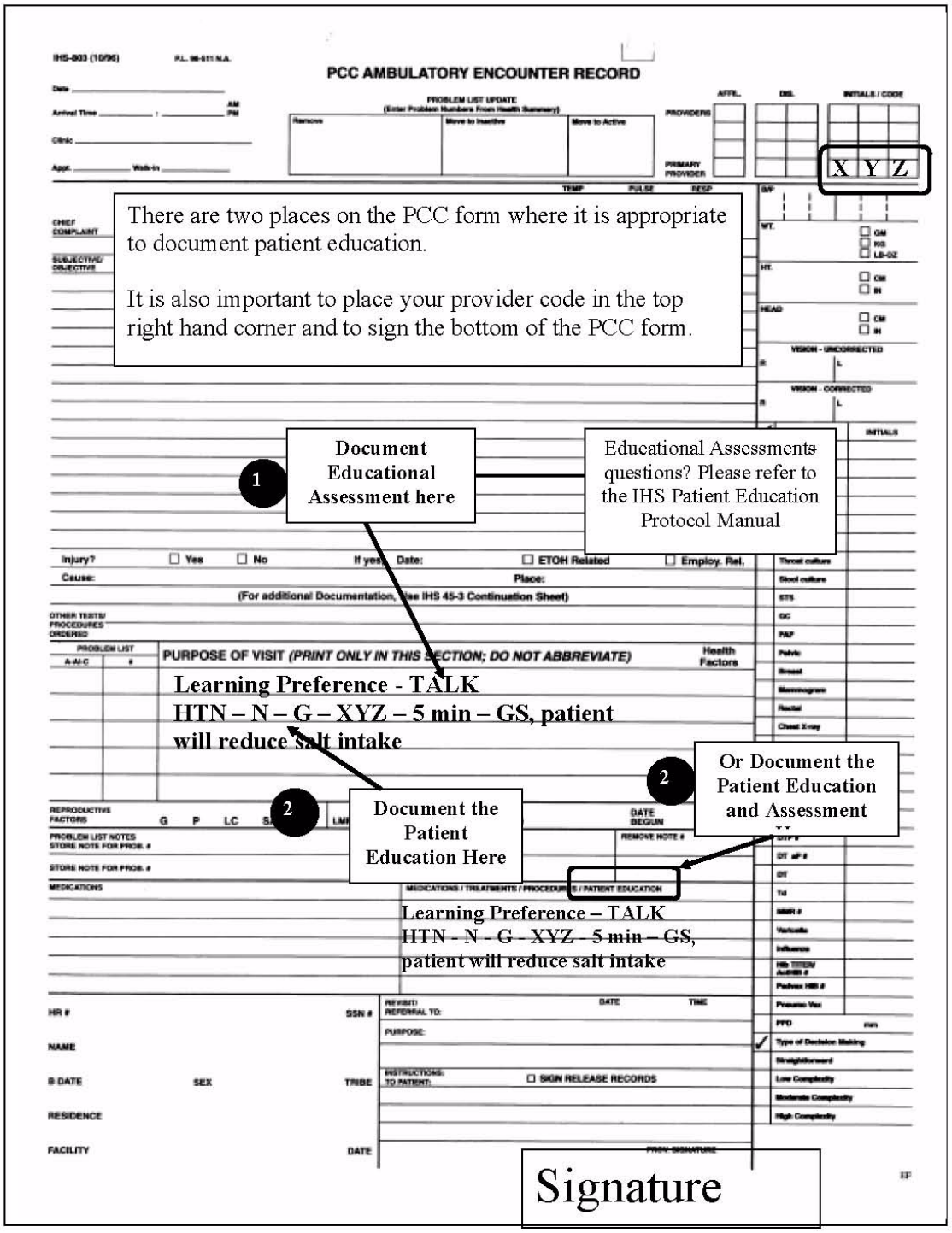
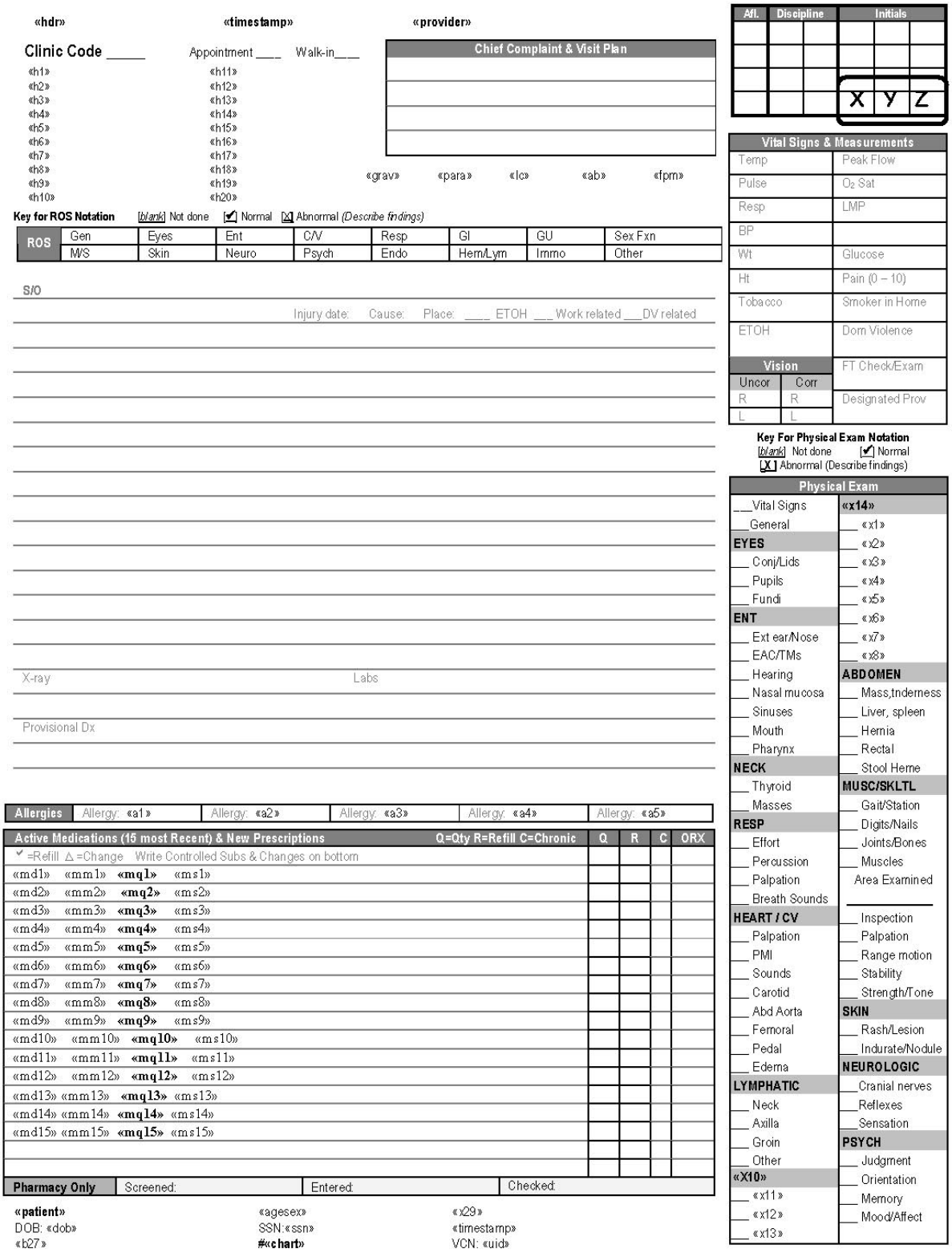


Figure 2: Documenting Patient Education with the PCC Ambulatory Encounter Record form

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



«hdr» «timestamp» «provider»

Clinic Code _____ Appointment ___ Walk-in___

«h1» «h11»
«h2» «h12»
«h3» «h13»
«h4» «h14»
«h5» «h15»
«h6» «h16»
«h7» «h17»
«h8» «h18»
«h9» «h19»
«h10» «h20»

Chief Complaint & Visit Plan

«grav» «para» «lc» «ab» «fpm»

Atl.	Discipline	Initials		
		X	Y	Z

Key for ROS Notation [blank] Not done [✓] Normal [X] Abnormal (Describe findings)

ROS	Gen	Eyes	Ent	C/V	Resp	GI	GU	Sex Fxn
	M/S	Skin	Neuro	Psych	Endo	Hem/Lym	Immo	Other

Vital Signs & Measurements	
Temp	Peak Flow
Pulse	O_2 Sat
Resp	LMP
BP	
Wt	Glucose
Ht	Pain (0 – 10)
Tobacco	Smoker in Home
ETOH	Dom Violence
Vision	FT Check/Exam
Uncor / Corr	
R / R	Designated Prov
L / L	

S/O

Injury date: Cause: Place: ____ ETOH ___ Work related ___DV related

X-ray Labs

Provisional Dx

Key For Physical Exam Notation
[blank] Not done [✓] Normal
[X] Abnormal (Describe findings)

Physical Exam	
___Vital Signs	«x14»
___General	___ «x1»
EYES	___ «x2»
___ Conj/Lids	___ «x3»
___ Pupils	___ «x4»
___ Fundi	___ «x5»
ENT	___ «x6»
___ Ext ear/Nose	___ «x7»
___ EAC/TMs	___ «x8»
___ Hearing	ABDOMEN
___ Nasal mucosa	___ Mass,tnderness
___ Sinuses	___ Liver, spleen
___ Mouth	___ Hernia
___ Pharynx	___ Rectal
NECK	___ Stool Heme
___ Thyroid	MUSC/SKLTL
___ Masses	___ Gait/Station
RESP	___ Digits/Nails
___ Effort	___ Joints/Bones
___ Percussion	___ Muscles
___ Palpation	Area Examined
___ Breath Sounds	_____
HEART / CV	___ Inspection
___ Palpation	___ Palpation
___ PMI	___ Range motion
___ Sounds	___ Stability
___ Carotid	___ Strength/Tone
___ Abd Aorta	SKIN
___ Femoral	___ Rash/Lesion
___ Pedal	___ Indurate/Nodule
___ Edema	NEUROLOGIC
LYMPHATIC	___ Cranial nerves
___ Neck	___ Reflexes
___ Axilla	___ Sensation
___ Groin	PSYCH
___ Other	___ Judgment
«X10»	___ Orientation
___ «x11»	___ Memory
___ «x12»	___ Mood/Affect
___ «x13»	

Allergies | Allergy: «a1» | Allergy: «a2» | Allergy: «a3» | Allergy: «a4» | Allergy: «a5»

Active Medications (15 most Recent) & New Prescriptions — Q=Qty R=Refill C=Chronic	Q	R	C	ORX
✓=Refill △=Change Write Controlled Subs & Changes on bottom				
«md1» «mm1» **«mq1»** «ms1»				
«md2» «mm2» **«mq2»** «ms2»				
«md3» «mm3» **«mq3»** «ms3»				
«md4» «mm4» **«mq4»** «ms4»				
«md5» «mm5» **«mq5»** «ms5»				
«md6» «mm6» **«mq6»** «ms6»				
«md7» «mm7» **«mq7»** «ms7»				
«md8» «mm8» **«mq8»** «ms8»				
«md9» «mm9» **«mq9»** «ms9»				
«md10» «mm10» **«mq10»** «ms10»				
«md11» «mm11» **«mq11»** «ms11»				
«md12» «mm12» **«mq12»** «ms12»				
«md13» «mm13» **«mq13»** «ms13»				
«md14» «mm14» **«mq14»** «ms14»				
«md15» «mm15» **«mq15»** «ms15»				

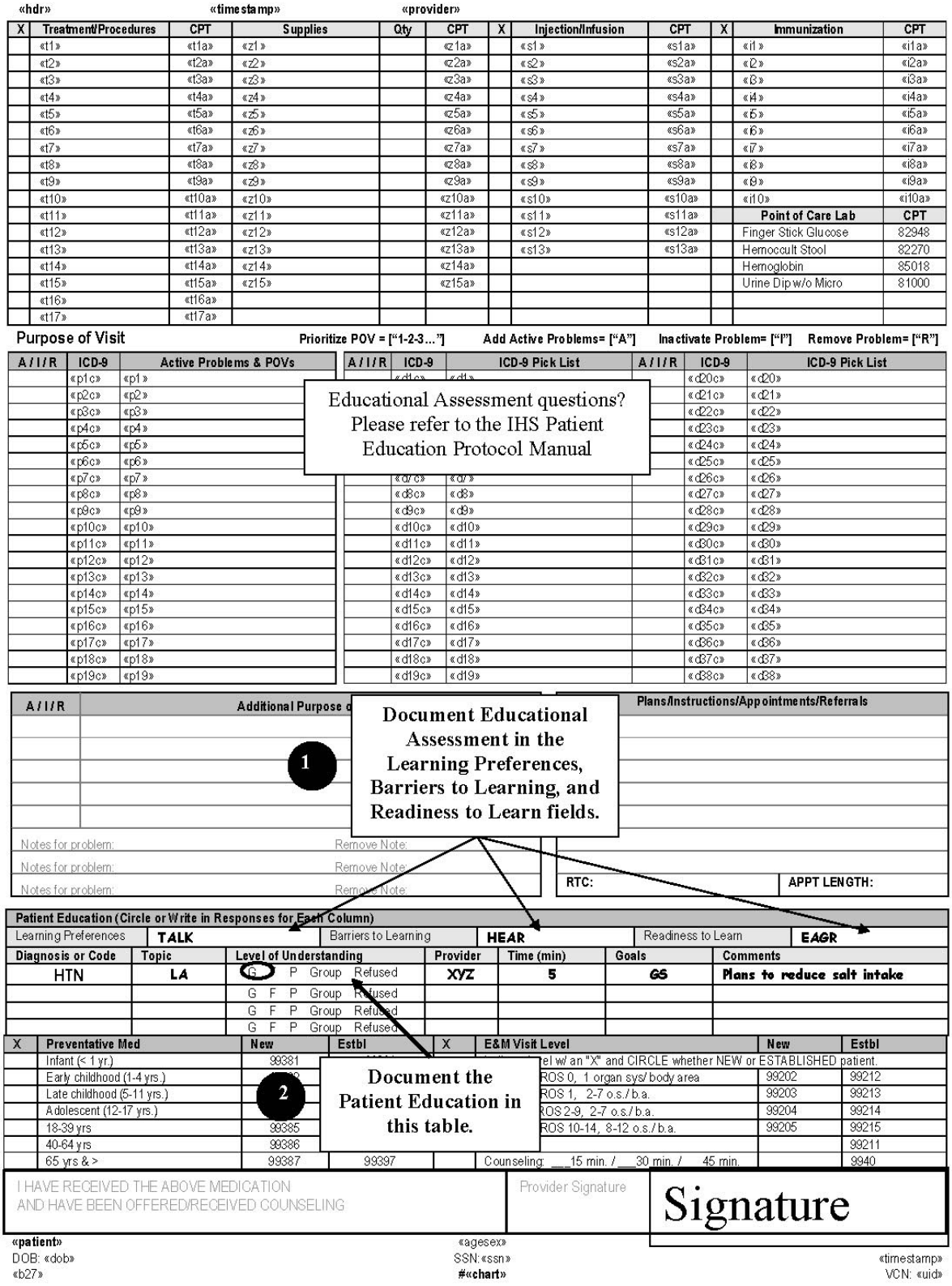
Pharmacy Only | Screened: | Entered: | Checked:

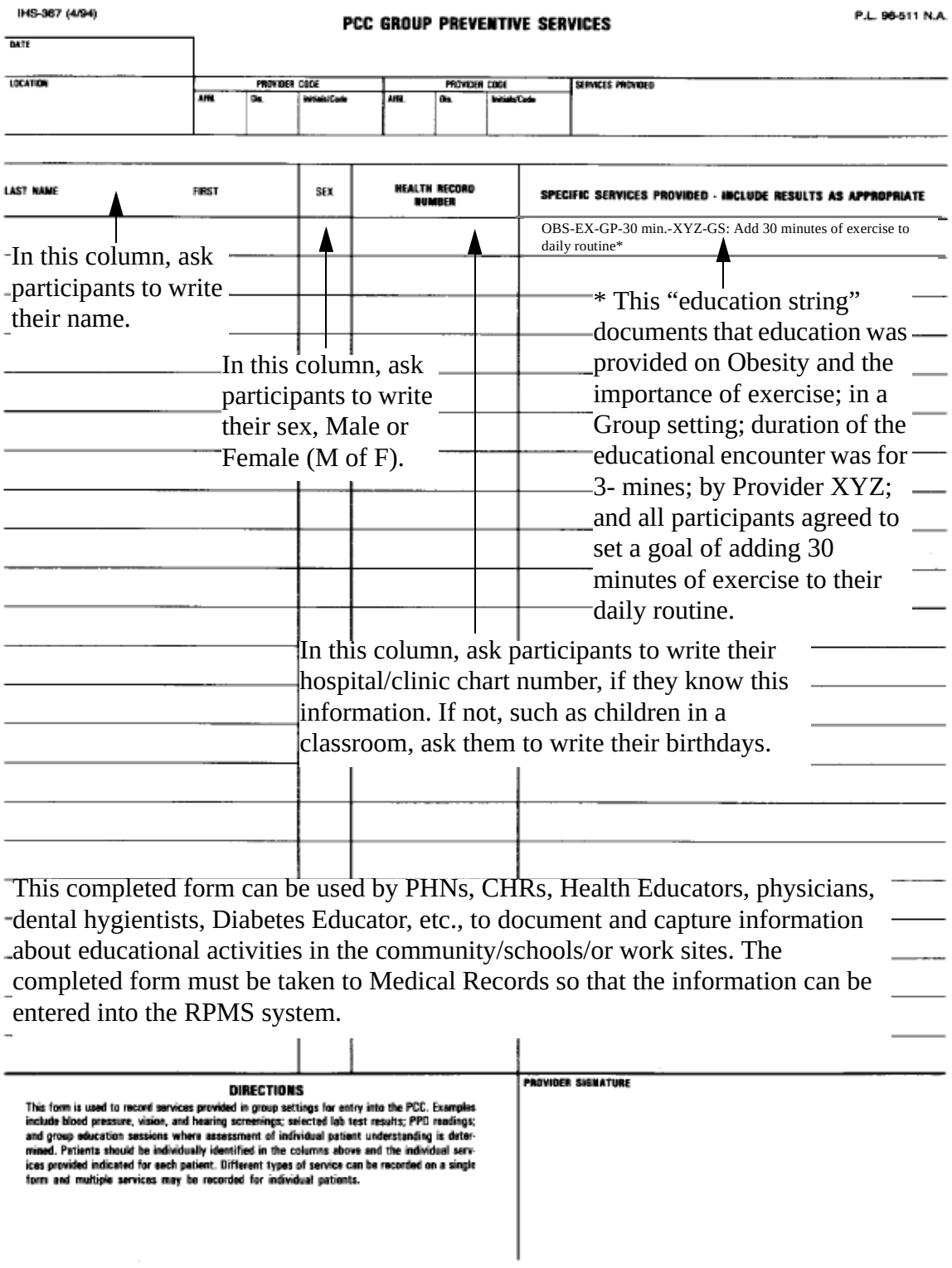
«patient»
DOB: «dob»
«b27»

«agesex»
SSN:«ssn»
#«chart»

«x29»
«timestamp»
VCN: «uid»

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





IHS-367 (4/94)

PCC GROUP PREVENTIVE SERVICES

P.L. 96-511 N.A.

DATE

LOCATION

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

PROVIDER CODE (AHA. | 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 of F).

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

* 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 3- mines; by Provider XYZ; and all participants agreed to set a goal of adding 30 minutes of exercise to their daily routine.

This completed form can be used by PHNs, CHRs, Health Educators, physicians, dental hygientists, Diabetes Educator, 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

Figure 5:Form used by all healthcare workers providing education in the community, schools, work sites, etc.

Recording Goals

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.

PSYCHOSOCIAL

You have the right to refuse to answer any of these questions

Depression Screen (Exam Code 36 Depression Screening Wellness tab)

Screening for pt ≤ 14 y/o: N/A □

Do you cry a lot? No Yes □

Do you cry for no apparent reason? No □ Yes □

Do you feel lonely even when other people are around No Yes **Refused:_____**

"Yes" to any question above OR if depression suspected in parent/caregiver & interfering with child's care, further evaluation indicated

In the last two weeks, how often have you been bothered by:

Little interest or pleasure in doing things?

__ (0) Not at all __(1) Several days __(2) More than half the days __(3) Nearly every day

Feeling down, depressed or hopeless: TOTAL SCORE_____

__ (0) Not at all __(1) Several days __(2) More than half the days __(3) Nearly every day

Normal/Negative ≤2 Abnormal ≥3 need further evaluation (using PHQ-9 or other diagnostic tool)

Tobacco (Health Factor Tobacco Wellness tab)

Do you (patient) currently use any Tobacco Products? (age 5yo) N/A □ **Refused:_____**

Any tobacco (cigarette/chewing) use in the last year? No □ Yes □ (Type_____ Amount_____How long_____)

No □ Non-Tobacco user

Yes □ Current smokerCurrent smokeless Current Smoker and Smokeless Ceremonial Use

Type_____ Amount_____ How long_____

If yes, educate about cessation options & document education

Have you ever used any Tobacco Products?

No □ Non-user

Yes □ Previous Smoker Previous Smokeless (Previous – no tobacco use for > 6 months)

Cessation Smoker Cessation Smokeless (Cessation – no tobacco use for < 6 months)

Any Exposure to Tobacco Smoke?

No Smoke free home

Yes Smoker in Home, Exposure to environmental Smoke (outside of home)

Alcohol/Drugs (Health Factor Alcohol/Drugs or Exam Code 35 Wellness tab)

Pt ≤ y/o: Do you (patient) or anyone in house use alcohol or drugs? No Self Other □ Comments _____

If yes for self, further evaluation indicated, document as exam code 35 – abnormal/positive **Refused _____**

If no for self, document as exam code 35 – normal/negative

If suspected in parent/caregiver & interfering with child's care, further evaluation indicated.

Do you use? Alcohol Marijuana Cocaine Meth Other Drugs How Often_____ How Long_____ NonUser____

Was last drink within the past 72 hours No Yes (If yes, consider CIWA)

Pt ≥ 21 y/o that has answered yes to alcohol - administer CAGE questionnaire:

C – Have you ever felt you should CUT down on your drinking? No Yes □

A – Have people ANNOYED you by criticizing your drinking?No Yes □

G – Have you ever felt bad or GUILTY about your drinking?No Yes CAGE Score____

E – Have you ever had a drink (or used drugs) first thing in the morning to steady your nerves, get rid of hangover or get the day started (EYEOPENER)? No □ Yes □

total yes 0/4 1/4 2/4 3/4 4/4

*if at least one yes further evaluation indicated

IPV/DV-Intimate Partner /Domestic Violence (Exam 34 Intimate Partner Violence, Wellness tab)

Ask of patient when no family/visitors are present. Peds, ask of parent/caregiver to determine if existence for patient.**Refused** _____

Do you feel safe with the people you live with or spend time with? No Yes Past □ **Unable** _____

Are you afraid to go home? No Yes Past □

Has anyone forced you to have sexual activities recently? No Yes Past □ Want Help: Yes No

INPATIENT EDUCATION FORM

READINESS TO LEARN (RL Code)	
Eager to Learn	**RL-EAGR**
Receptive	**RL-RCPT**
Unreceptive	**RL-UNRC**
Pain	**RL-PAIN**
Severity of Illness	**RL-SVIL**
Distraction	**RL-DSTR**
Assessed each teaching session	

PATIENT'S RESPONSE TO EDUCATION (Level of Understanding Code)

- G - GOOD - *Verbalized understanding. Able to return demonstration or teach back correctly.*
- F - FAIR - *Verbalizes need for more education. Incomplete return demonstration or teach back indicates partial understanding.*
- P - POOR - *Does not verbalize understanding. Unable to return demonstration or teach back.*
- R - REFUSED - *Refuses education.*
- GP - GROUP - *Education provided in group. Unable to evaluate individual response.*

LEARNING PREFERENCES (LP Code)			
Group	Read	Talk (one on one)	Media
☐ **LP –GP**	☐ **LP –READ**	☐ **LP –TALK**	☐ **LP –MEDIA**

BARRIERS TO LEARNING (BAR) *(Check those that apply)*					☐ Pediatric/Develop **BAR-PEDI**
☐ No Barrier **BAR-NONE**	☐ Cognitive Impairment **BAR-COGI**	☐ Doesn't Read English **BAR-DNRE**	☐ Fine Motor Skills **BAR-FIMS**	☐ Interpreter Needed **BAR-INTN**	☐ Values/Beliefs **BAR-VALU**
☐ Blind **BAR-BLIND**	☐ Visually Impaired **BAR-VISI**	☐ Hard of Hearing **BAR-HEAR**	☐ Deaf **BAR-DEAF**	☐ Social Stressors **BAR-STRS**	☐ Emotional Impairment **BAR-EMOI**

Date/ Time	Readiness to Learn	Patient Education Code	Understanding	Person Taught	Provider Signature/Code	Time (min)	Goal Set, Met, Not Met (state specific goal)
		ADM –POC Plan of Care	G F P R Gp	☐ Patient ☐ Other			
		ADM-OR,S Orientation, Safety	G F P R Gp	☐ Patient ☐ Other			
		ADV – I Advance Directive Info	G F P R Gp	☐ Patient ☐ Other			
		_____-N fill in code for nutrition education	G F P R Gp	☐ Patient ☐ Other			
		DCH-M Discharge Medication education	G F P R Gp	☐ Patient ☐ Other			
		DCH – POC,FU Plan of care, follow-up	G F P R Gp	☐ Patient ☐ Other			

Date	GPRA Screening	Result	Pt Education if "positive" screen	Time	Provider
	Int. Partner/Dom. Violence Exam Code #34	☐ Negative ☐ Present ☐ Past ☐ Refused ☐Unable	☐ N/A RL: Person: DV-_____ Understanding: Goal Set? ____what?_____		
	Alcohol Exam Code #35 -or- Health Factor	☐ Normal/Negative ☐ Abnormal/Positive ☐ Refused CAGE /4 (health factor only)	☐ N/A RL: Person: AOD-_____ Understanding: Goal Set? ____what?_____		
	Depression Exam Code #36	☐ Normal/Negative ☐ Abnormal/Positive ☐ Refused	☐ N/A RL: Person: DEP-_____ Understanding: Goal Set? what?		
	Tobacco Health Factor	☐ Non Tobacco User ☐ Smoke Free Home Circle all qualifiers for tobacco use: Cessation: Smoker/Smokeless Current: Smoker/Smokeless Previous: Smoker/Smokeless Exposure to Environ. Smoker in home	☐ N/A RL: Person: TO-_____ Understanding: Goal Set? ____what?_____		

«patient»		Chart # «chart»	«timestamp»
DOB: «dob»	«agesex»	PCP: «b14»	VCN: «uid»
«b27»			

Figure 1: Documenting Inpatient Education Record, Part 1

INPATIENT EDUCATION FORM

Commonly Used Illness or Condition Codes And specific topics related to those codes		Commonly Used Education Topics
ASM – Asthma	HTN - Hypertension	C – Complications
PL - Pulmonary	IM - Immunization	DP – Disease Process
ASM/PL – MDI meter dose inhaler	IM - DEF deficiency	EQ - Equipment
ASM/PL – NEB nebulizer	IM - SCH schedule	EX – Exercise
ASM/PL - PF peak flow	INJ - Injuries	FU – Follow Up
ASM/PL – SPA spacer	INJ - CC cast care	HM - Home Management
BL - Blood Transfusion	INJ - WC wound care	I - Information
CP - Chest Pain	MEDS –Medical Safety	L - Literature
CHF – Heart Failure	PM - Pain Management	LA - Lifestyle Adaptations
CKD – Chronic Kidney Disease	PT - Physical Therapy	M - Medications
CPM - Chronic Pain Management	PT - GT gait training	N - Nutrition
DM - Diabetes	PT - WC wound care	P - Prevention
DV - Domestic Violence	PNM - Pneumonia	PM - Pain Management
LIP - Dyslipidemia	PNM/PL-IS incent spirom	S - Safety
EOL - End of Life	RS - Restraints	SHS –Second Hand Smoke
EOL – GP grieving process	SWI - Skin & Wound Infections	TE - Tests
EOL – LW living will	SWI – WC wound care	TO - Tobacco
F - Fever	TO - Tobacco Use	TX - Treatments
GER – GERD	URI - Upper Respiratory Infection	

Date/Time	Readiness to Learn Code (RL)	Education Code and Topics *(√box to refer to Progress Notes)*	Understanding Code	Person Taught	Provider Signature/Code	Time	Goal Set, Met, Not Met (state specific goal)
		☐	G F P R Gp	☐ Patient ☐ Other			
		☐	G F P R Gp	☐ Patient ☐ Other			
		☐	G F P R Gp	☐ Patient ☐ Other			
		☐	G F P R Gp	☐ Patient ☐ Other			
		☐	G F P R Gp	☐ Patient ☐ Other			
		☐	G F P R Gp	☐ Patient ☐ Other			
		☐	G F P R Gp	☐ Patient ☐ Other			
		☐	G F P R Gp	☐ Patient ☐ Other			
		☐	G F P R Gp	☐ Patient ☐ Other			
		☐	G F P R Gp	☐ Patient ☐ Other			
		☐	G F P R Gp	☐ Patient ☐ Other			
		☐	G F P R Gp	☐ Patient ☐ Other			

«patient»		Chart # «chart»	«timestamp»
DOB: «dob»	«agesex»	PCP: «b14»	VCN: «uid»

Figure 2: Documenting Inpatient Education Record, Part 2

New Codes for 2006

The following codes are new to the 2006 Patient Protocol and Coding Manual 12th edition.

ADM ADMISSION TO HOSPITAL

ALZ ALZHEINER'S DISEASE

ASM ASTHMA

CA CANCER

CDC COMMUNICABLE DISEASES

CAD CORONARY ARTERY DISEASE

CRP CROUP

CF CYSTIC FIBROSIS

DEH DEHYDRATION

DC DENTAL CARIES

ECC EARLY CHILDHOOD CARIES

ELD ELDER CARE

FP FAMILY PLANNING

GAD GENERALIZED ANXIETY DISORDER

GRIEF GRIEF

SZ SEIZURE DISORDER

SUP SUPPLEMENT, DIETARY

SPE SURGICAL PROCEDURES AND ENDOSCOPY

TO TOBACCO

TB TUBERCULOSIS

WH WOMEN'S HEALTH

General Education Subtopics

(using EDC-9 diagnosis instead of PEPC to document education)

Guidelines For Use

The following subtopic can be used in conjunction with any ECD-9 diagnosis to document patient/family education. The general subtopics should not be used with standard patient education codes. Standard codes can be found in the IHS Patient Education Protocols and Codes Manual (PEPC). As with PEPC, covering 50% of the standards under a subtopic justifies use of the education coding system. The list below is NOT exhaustive, nor is it intended to be.
The provider will write out the following: 1) ICD-9 code or diagnosis, 2) education subtopic, 3) level of understanding (G, F, P, R, Gp), 4) Provider Code or Initials, 5) Time spent providing the education, and 6) GS for Goal set, GM for Goal Met, and GNM for Goal Not Met if the patient set a goal. For example:

(132.9) Pediculosis – TX – F <provider initials> 10min. – GS: Pt. will wash linens

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

(132.9) Pediculosis – treatment – fair understanding, 10 minutes, Goal Set: Pt. will wash linens

The General Education Subtopics used with ICD-9 diagnoses are:

AP - Anatomy & Physiology
C - Complications
DP - Disease Process
EQ - Equipment
EX - Exercise
FU - Follow-up
HM - Home Management
HY - Hygiene
L - Literature
LA - Lifestyle Adaptations
M - Medications
MNT - Medical Nutrition Therapy (Reg. Dietitian use only)
N - Nutrition
P - Prevention
PRO - Procedures
S - Safety
TE - Tests
TX - Treatment

General Education Subtopics Listing

AP - ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand the anatomy and physiology as it relates to the disease state or condition.

STANDARDS:

1. Explain normal anatomy and physiology of the systems 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/family will understand the effects and consequences as a result of this disease state/condition, the failure to manage this disease state/condition, or those that are a result of treatment.

STANDARDS:

1. Discuss the common or significant complications associated with the disease state/ condition.
2. Discuss common or significant complications that may be prevented by full participation with the treatment plan.
3. Discuss common or significant complications that may result from treatments.

DP - DISEASE PROCESS

OUTCOME: The patient/family will understand the condition/disease.

STANDARDS:

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

EQ - EQUIPMENT

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

STANDARDS:

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

EX - EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in the patient's disease process.

STANDARDS:

1. Discuss the medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Discuss the barriers to a personal exercise plan and the solutions to those barriers. Assist the patient in developing a personal exercise plan.
4. Encourage the patient to increase the intensity and duration of the activity as the patient becomes more fit, as appropriate.
5. Refer to community resources as appropriate.

FU - FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss the signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

HM - HOME MANAGEMENT

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

STANDARDS:

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

HY - HYGIENE

OUTCOME: The patient/family 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 - LITERATURE

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

STANDARDS:

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

LA - LIFESTYLE ADAPTATIONS

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

STANDARDS:

1. Review the lifestyle aspects/changes that the patient has control over: nutrition, physical activity, safety and injury prevention, avoidance of high risk behaviors, and full participation in the treatment plan.
2. Emphasize that an important component in the prevention or treatment of the 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 purpose, proper use, and expected outcomes of their drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the benefits and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

MNT - MEDICAL NUTRITION THERAPY

(* FOR USE BY REGISTERED DIETITIANS ONLY ***)**

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed in the disease state/condition.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.

e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

N - NUTRITION

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

STANDARDS:

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

P - PREVENTION

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

STANDARDS:

1. Discuss lifestyle behaviors that increase the risk for the onset, progression, or spread of a specific disease/condition.
2. Discuss the behaviors that reduce the risk for the onset, progression, or spread of a specific disease/condition.

PRO - PROCEDURES

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

STANDARDS:

1. Discuss the indications, risks, and benefits for the proposed procedure as well as the alternatives and the risk of non-treatment.
2. Explain the process and what is expected after the procedure.
3. Explain the necessary preparation, e.g., 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 the principals of injury prevention and will plan for a safe environment.

STANDARDS:

1. Explain that injuries are a major cause of death/disability.
2. Discuss injury prevention adaptations appropriate to the patient's age, disease state, or condition (home safety, car safety, work safety, recreation safety).
3. Identify community resources that promote safety and injury prevention. Provide information regarding key contact for emergencies, e.g., 911, Poison Control, hospital ER, police.

TE - TESTS

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

STANDARDS:

1. Explain the test ordered as well as the collection, benefits, and risk of the test to be performed. Explain how the ordered test relates to the course of treatment.
2. Explain any necessary preparation/instructions for the test, e.g., fasting.
3. Explain how to obtain the test results and test interpretation as appropriate.

TX - TREATMENT

OUTCOME: The patient/family will understand the mutually agreed upon treatment plan.

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and the adherence to the treatment plan.
2. Explain that various treatments have their own inherent risk, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
3. Refer to community resources as appropriate.

MNT—Medical Nutrition Therapy

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

Medical Nutrition Therapy (MNT) is the use of specific nutrition interventions based on standardized guidelines that incorporate current professional knowledge and research to treat an illness, injury, or condition. Nutrition interventions are determined on an assessment that includes a review and analysis of medical and diet history, biochemical and anthropocentric measures. MNT plays a key role thought out the life cycle of an individual and integrates in the continuum of care in all levels of practice.

The Dietetic Practitioner, also referred to as a Registered Dietitian (RD), is the professional 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 completed a pre-professional experience, and has successfully completed the Registration Examination for Dietitians. All RDs must accrued 75 hours of approved continuing professional education every 5 years to maintain Registration through the Commission on Dietetic Registration.

Education Needs Assessment Codes

INDIAN HEALTH SERVICE
EDUCATION NEEDS ASSESSMENT CODES

LP - Learning PreferenceMnemonics

1. Talk LP-TALK
2. Media LP-MEDIA
3. Group LP-GP
4. Read LP-READ

RL - Readiness to Learn

1. Eager RL-EAGR
2. Receptive RL-RCPT
3. Unreceptive RL-UNRC
4. Pain RL-PAIN
5. Severity of Illness RL-SVIL
6. Distraction RL-DSTR

BAR - Barriers to Learning

1. No BarriersBAR-NONE
2. Does Not Read EnglishBAR-DNRE
3. Interpreter NeededBAR-INTN
4. Cognitive ImpairmentBAR-COGI
5. Fine Motor Skills DeficitBAR-FIMS
6. Hard of HearingBAR-HEAR
7. Deaf BAR-DEAF
8. Visually ImpairedBAR-VISI
9. Blind BAR-BLND
10. Social Stressors BAR-STRS
11. Emotional BAR-EMOT
12. Values/Belief BAR-VALU
13. Pediatric/DevelopmentalBAR-PEDI

BAR—Barriers to Learning

Barriers to learning are PATIENT specific and documented as a Health Factor in the medical record. They usually are not visit specific, but rather relate to the patient's overall health status. Barriers are assessed by observation and interview, and then documented to alert other healthcare providers that may provide education. It is important to accommodate and overcome barriers in order to enhance patient learning. Examples of how to overcome barriers to learning may include:

- Involve a family member or care taker in the education
- Minimize education to "need to know" information
- Speak loudly and clearly
- Communicate in writing
- Provide written materials that are low-literacy and have demonstrative pictures
- Refer to mental health, social services, or community resources as appropriate
- Assist the patient in identifying adaptive technique or equipment that could accommodate the impairment.
- Utilize a translator or sign interpreter
- Use different size medication bottles or a medication box
- Use medical assisted devices
- Ask the patient: "Do you feel ready for this education session or is there too much going on right now? When would be a better time for you?"

BAR-BLND BLIND

DEFINITION: The patient is blind and can not compensate with low-vision devices.

ASSESSMENT: The patient may divert the eyes, wear sunglasses inside, state an inability to see or is diagnosed with blindness (best corrected vision is ≤ 20/200 **or** ≤20 degrees of visual field in the better eye).

BAR-COGI COGNITIVE IMPAIRMENT

DEFINITION: The patient may have difficulty learning because of impaired thought processes.

ASSESSMENT: The patient may answer questions inappropriately, behave inappropriately or display symptoms of confusion or forgetfulness. The patient may have a documented diagnosis of dementia, developmental delay, learning disability, or intoxication.

BAR-DEAF DEAF

DEFINITION: The patient is deaf and can NOT compensate with increased volume or hearing devices.

ASSESSMENT: The patient may not respond to questions, may be looking intently at your lips as you speak, may motion to communicate by writing, use sign language to indicate deafness, or may have a diagnosis of deafness.

BAR-DNREDOES NOT READ ENGLISH

DEFINITION: The patient is unable to read English.

ASSESSMENT: Ask the patient/family about the ability to read English. Patients may be embarrassed admitting they cannot read English or may make excuses such as "I forgot my glasses." This is a sensitive subject and must be treated accordingly. Stress "English" in this evaluation and acknowledge that the patient's primary language may be unwritten. Another technique is to have the patient read a sentence that could be interpreted in different ways and ask them how they interpret the sentence. If the patient is unable, state that reading English can be hard for people that learned another language first and ask if this is applicable.

BAR-EMOT EMOTIONAL STRESSORS

DEFINITION: The patient's ability to learn is limited due to emotional stressors.

ASSESSMENT: The patient may appear distraught, avoid eye contact, or show anger. The emotional stressors may be acute or ongoing. e.g., personal issues (martial/ relationship problems, unemployment/financial stress, lack of housing, problems with children/family members) or behavioral issues (mood, anxiety, grief). Emotional stressors are internal while social stressors are external.

BAR-FIMS FINE MOTOR SKILLS DEFICIT

DEFINITION: The patient has fine motor skills impairment that can interfere with tasks requiring manual dexterity.

ASSESSMENT: The patient may have difficulty or lack the physical control to direct/ manage body movement, e.g., paralysis, arthritis, amputation, unable to handle testing supplies (for example, checking blood sugars or measuring medications).

BAR-HEAR HARD OF HEARING

DEFINITION: The patient has a problem hearing that can be compensated with increased volume or hearing devices.

ASSESSMENT: The patient may not respond to questions initially and may ask for things to be repeated, may speak loudly, may end ear/lean toward the speaker, or wears a hearing device.

BAR-INTN INTERPRETER NEEDED

DEFINITION: The patient does not readily understand spoken English.

ASSESSMENT: The patient may verbalize the need for an interpreter, answer questions inappropriately, or answer or nod "yes" to all questions. These actions could also imply hearing difficulty and may require further assessment.

BAR-NONE NO BARRIERS

DEFINITION: The patient has no apparent barriers to learning.

BAR-PEDI PEDIATRIC/DEVELOPMENTAL

DEFINITION: That patient has normal cognitive development but is too young to understand health information. There is no cut off age for this because childhood cognition can develop at different rates.

ASSESSMENT: The pediatric patient is of an age/cognition level that relies on others for care.

BAR-STRS SOCIAL STRESSORS

DEFINITION: The patient's ability to learn is limited due to social stressors from current personal difficulties or on-going mental/behavioral health issues

ASSESSMENT: The patient may appear distraught, avoid eye contact, or show anger. The stressors may be acute or ongoing. e.g., family separation and conflict, mental disorders, disease, death, alcohol/substance abuse, domestic violence. Social stressors are external while emotional stressors are internal.

BAR-VALU VALUES/BELIEF

DEFINITION: The patient has values or beliefs that may impact learning; this may also include traditional Native American/Alaska Native values/beliefs that might impact the medical/clinical aspects of healthcare.

ASSESSMENT: The patient may comment or be asked about values/beliefs in relation to health information or medical/clinical aspects of healthcare.

BAR-VISI VISUALLY IMPAIRED

DEFINITION: The patient has difficulty seeing even with best corrected vision. The difficulty can be compensated with the use of other measures/devices to improve vision (large print, better lighting, magnifying glasses).

ASSESSMENT: The patient may divert the eyes, squint, or state having difficulty seeing.

LP—Learning Preference

Learning Preference is listed in the medical record as a Health Factor. Although a patient may have a predominant way of learning, it is important to use a variety of teaching methods to optimize an education encounter. Learning preference can be evaluated when the provider deems it necessary.

The procedure for Evaluating Learning Preference is as follows:

1. Review the most common styles of adult learning (talking & asking questions, group discussion, videos, reading)
2. Explain that every individual is unique and will have their own preference(s) in how they receive new information.
3. Ask the patient/family, "How do you learn best?"

LP-GP GROUP

DEFINITION: The patient/family will state that participating in small groups is the preferred style of learning. A group is more than one person.

LP-READ READ

DEFINITION: The patient/family will state that reading is the preferred style of learning.

LP-MEDIA MEDIA

DEFINITION: The patient/family will state that media (kiosk, videos, interactive displays, demonstrations, or pictorial teaching) is the preferred style of learning.

LP-TALKTALK

DEFINITION: The patient/family will state that talking and asking questions is the preferred style of learning.

RL—Readiness to Learn

Readiness to Learn can be assessed through both observation and interview. Readiness to Learn is sub-topic specific while Barriers apply to the overall health status of the patient. With few exceptions (emotional, social and cognitive), Barriers to Learning tend to be more physical and slower to change.

Because of current system constraints, Readiness to Learn is documented via the Health Factors. In the future, this may be moved to be a data element under specific education subtopics.

RL-DSTR DISTRACTION

DEFINITION: The patient/family has limited readiness to learn because of distractions that cannot be minimized.

RL – EAGR EAGER

DEFINITION: The patient/family is exceedingly interested in receiving education.

RL – RCPT RECEPTIVE

DEFINITION: The patient/family is ready or willing to receive education.

RL-PAIN PAIN

DEFINITION: The patient/family has a level of pain that limits readiness to learn.

RL-SVIL SEVERITY OF ILLNESS

DEFINITION: The patient/family has a severity of illness that limits readiness to learn.

RL-UNRC UNRECEPTIVE

DEFINITION: The patient/family is NOT ready or willing to receive education.

A

ACNE - Acne

ACNE-C COMPLICATIONS

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

STANDARDS:

1. Explain that uncontrolled acne may result in scaring.
2. Discuss that picking at acne lesions will increase the risk of skin infections and scars.
3. Explain that the following characteristics are common in persons with acne (especially severe acne):
   a. Low self esteem
   b. Social withdrawal
   c. Reduced self-confidence
   d. Poor body image
   e. Embarrassment
   f. Depression
   g. Anger
   h. Preoccupation with body image
   i. Frustration
   j. Higher rates of unemployment than persons without acne

ACNE-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the basics of acne.

STANDARDS:

1. Explain that there are three major components that lead to acne.
   a. Seum (dead skin cells, hair., etc.)
   b. Bacteria
   c. Increased oil production as a result of testosterone
2. Explain that the above factors combine to plug the pore and result in acne.

3. Explain that acne is common in adolescence due to increased levels of hormones but may occur in adults as well and may be related to hormonal influences such as the menstrual cycle, childbirth, menopause or stopping hormone therapies such as birth control pills.
4. Explain that the lesions of acne can range in severity from open and closed comedones (blackheads and whiteheads) to pustules and nodules.
5. Discuss that the most common distribution of acne is the face, neck, chest, back, shoulders, and upper arms.
6. Discuss that some people are more prone to develop acne because of hereditary factors.
7. Explain that the role of stress of acne is not elucidated.

ACNE-FU FOLLOW UP

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

STANDARDS:

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

ACNE-HY HYGIENE

OUTCOME: The patient/family will understand hygiene and how it relates to acne.

STANDARDS:

1. Explain that acne is not caused by poor hygiene.
2. Discuss that harsh or frequent washing of the skin can make acne worse. Explain that the best way to wash acne prone areas is gentle washing with a mild soap followed by patting to dry the skin.

3. Discuss that cosmetics may worsen acne. If cosmetics are to be worn, they should be non-acneogenic and not applied heavily. Cosmetics should be removed nightly with a gentle cleanser and water.
4. Explain that hairsprays and gels can make acne worse and the face should be shielded from these products.
5. Discuss that shaving lightly after thoroughly softening the beard with soap and water before applying shaving cream will decrease the likelihood of nicking blemishes.
6. Explain that acne lesions should not be picked at.

ACNE-L LITERATURE

OUTCOME: The patient/family will receive literature about child health issues.

STANDARDS:

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

ACNE-M MEDICATIONS

OUTCOME: The patient/family will understand the use of medication in the treatment of acne.

STANDARDS:

1. Discuss that acne treatments may be topical, oral, or a combination of the two.
2. Explain that many medications may take several weeks to work and often make acne worse before getting better.
3. Discuss the risks and benefits of different therapies available.
4. Explain medication name, actions, directions for use, and risks/benefits of therapy.
5. Discuss common and important side effects, home management, and side effects that should prompt follow-up.
6. Discuss the proper storage of medication.
7. Discuss food/drug and drug/drug interactions.
8. Explain, as appropriate, the need for registration for isotrentinoin therapy, lab tests, pregnancy tests, warnings for suicidal behavior, and birth control as appropriate.

ACNE-N NUTRITION

OUTCOME: The patient/family will understand the role of diet in acne.

STANDARDS:

1. Explain that no food has been linked with worsening acne.
2. Discuss and dispel common myths related to diet and acne, such as chocolate, french fries, and pizza causing acne.

ACNE-TX TREATMENT

OUTCOME: The patient/family will understand the treatment plan and treatment goals.

STANDARDS:

1. Explain that mild acne will usually go away on its own after a few years.
2. Discuss that treatment of acne is an ongoing process and that all acne treatments work by preventing new breakouts.
3. Explain that existing lesions heal on their own and not as a result of the acne treatment.

ABD - Abdominal Pain

ABD-C COMPLICATIONS

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

STANDARDS:

1. Explain that some possible complications are acute hemorrhage, sustained hypotension and shock, perforation of an organ, and infections.
2. Advise the patient/family that complications may be prevented with prompt treatment. Increasing-pain, persistent fever, bleeding, or altered level of consciousness should prompt immediate follow-up.

ABD-DP DISEASE PROCESS

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

STANDARDS:

1. Discuss various etiologies for abdominal pain, e.g., 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 in the treatment of abdominal pain.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

ABD-L LITERATURE

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

STANDARDS:

1. Provide parent/family with literature on abdominal pain.
2. Discuss the content of the literature.

ABD-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

ABD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of abdominal pain.

STANDARDS

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ABD-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition and abdominal pain.

STANDARDS:

1. Discuss possible foods that may exacerbate abdominal pain as appropriate.
2. Omit possible offenders such as alcohol, caffeine, and aspirin.
3. Explain the benefits of keeping a food diary to identify foods that may be associated with pain.
4. Refer to a registered dietitian for MNT.

ABD-PM PAIN MANAGEMENT

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

STANDARD:

1. Discuss, as appropriate, that some foods might exacerbate abdominal pain.
2. Explain that administration of pain medications may be delayed until the etiology of the pain is determined.
3. Explain that chronic, escalating or uncontrolled pain should be reported.
4. Explain that administration of fluids, narcotics, other medications and non-pharmacologic measures may be helpful in managing pain and associated symptoms.

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. Maintaining a healthy diet
g. Regular physical activity
h. Taking vacations
i. Practicing meditation, self-hypnosis, and positive imagery
j. Practicing relaxation methods such as deep breathing or progressive muscular relaxation
k. Participating in 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 test(s) that have been ordered and collection method.
3. Explain the 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 and instructions for the test, e.g., nothing by mouth, enemas.

ABD-TX TREATMENT

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

STANDARDS:

1. List the therapy(ies) that may be indicated. Discuss the risk(s) and benefit(s) of the proposed treatment(s) as well as the risk of non-treatment.

AF - Administrative Functions

AF-B BENEFITS OF UPDATING CHARTS

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

STANDARDS:

1. Identify benefits to the patient, e.g., insurance deductible without co-payment, increased services at this facility.
2. Identify benefits to the hospital/clinic, e.g., increase of services through third party collections.
3. Refer the patient to benefits coordinator or other resources as appropriate.

AF-CON CONFIDENTIALITY

OUTCOME: The patient/family will understand that the patient's health information will be kept confidential.

STANDARDS:

1. Briefly explain the institution's policies regarding confidentiality and privacy of protected health information under the current regulations.
2. Explain the instances where patient information might be divulged, (third-party billing, continuation of care, transfer to another facility) and what information will be divulged.
3. Explain that a "Release of Information" will be obtained prior to release of medical information except when related to continuation of care, billing, or transfer to another facility.
4. Explain that information will not be provided to others, including family and friends, without written permission from the patient.
5. As indicated, emphasize the importance of respecting the right to confidentiality and privacy of other patients.

AF-FU FOLLOW-UP

OUTCOME: The patient/family will keep the business office updated regarding their demographic data at every visit.

STANDARDS:

1. Discuss the importance of maintaining updated information in order to enable the physician or other provider to contact the patient in case of emergency or lab results that need immediate attention.
   a. Address
   b. Telephone number
   c. Emergency contact
   d. Third party payers, if any
   e. Name changes
2. Discuss the procedure for providing updated and current information as soon as it becomes available.
3. Explain that updated information will improve the delivery of care and treatment at the T/I/U Clinic/Hospital.
4. Explain that no discrimination will occur based on availability of third party payment resources.
5. Discuss the importance of follow-up care and the requirement to notify contract health services of any future appointments and procedures in the private sector. Referrals are for one visit only.

AF-REF REFERRAL PROCESS

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

STANDARDS:

1. Emphasize that referrals to outside providers by Indian Health Service primary providers typically will be processed by Contract Health Services.
2. Explain that the procedure for the referral to the private sector is usually based on a priority system and/or waiting list.
3. Explain that coverage by insurance companies and Medicare/Medicaid packages will be utilized prior to contract health service funds in most cases. The Indian Health Service is a payer of last resort.
4. Discuss the rules/regulations of Contract Health Services.
5. Refer as appropriate to community resources for Medicaid/Medicare enrollment, e.g., benefits coordinator.

6. Explain that future and/or additional referrals must be approved prior to the appointment.
7. Explain the institution's process for appealing Contract Health denials.
8. Discuss the institution's Contract Health process for dealing with after hours emergency room/urgent care visits.

AF-RI PATIENT RIGHTS AND RESPONSIBILITIES

OUTCOME: The patient/family will understand the patient's rights and responsibilities.

STANDARDS:

1. Explain to the patient/family of the patient's rights and responsibilities.
2. Discuss the patient's rights to privacy and confidentiality with exceptions for patient safety and harm to self/harm to others as appropriate.
3. Explain to the patient/family the process for addressing conflict resolution and grievance.

ADM - Admission to Hospital

ADM-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family/caregiver will understand the process of developing an advance directive and its role in maintaining a sense of control in the patient's medical care and decisions.

STANDARDS:

1. Explain that patients may lose the ability to make their own decisions and an advance directive will be able to express the patient's desires prior to the loss of decision-making abilities.
2. Review the option of Advanced Directives/Living Will with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
3. Refer to appropriate services to assist the patient in making a living will, e.g., Social Services, Clergy, Lawyer.
4. **Refer to "ADV - Advance Directives" on page 40**.

ADM-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

ADM-EQ EQUIPMENT

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

STANDARDS:

1. Identify and discuss the indications for and benefits of the specific hospital equipment.
2. Discuss the types and features of hospital equipment as appropriate.
3. Instruct the patient regarding necessary involvement and cooperation in the use of equipment, as appropriate.
4. Emphasize safe use of the equipment, e.g., no smoking around O_2, use of gloves, electrical cord safety. Discuss proper disposal of associated medical supplies as appropriate.
5. Emphasize the importance of not tampering with patient care equipment.
6. Explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.

ADM-OR ORIENTATION

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

STANDARDS:

Discuss any or all of the following as applicable:

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

8. Discuss the hospital policy regarding home medications/supplements brought to the hospital.

ADM-PM PAIN MANAGEMENT

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

STANDARDS:

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

ADM-POC PLAN OF CARE

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

STANDARDS:

1. Explain the basic plan of care for the patient, including the following, as appropriate:
   a. Probable length of stay and discharge planning.
   b. Anticipated assessments.
   c. Tests to be performed, including laboratory tests, x-rays, and others.
   d. Therapy to be provided, e.g., medication, physical therapy, dressing changes.
   e. Advance directives. **Refer to "ADV - Advance Directives" on page 40**.
   f. Plan for pain management.
   g. Nutrition and dietary plan including restrictions, if any.
   h. Restraint policy and conditions for release from restraints as applicable.
2. Discuss the expected outcome of the plan.

ADM-RI PATIENT RIGHTS AND RESPONSIBILITIES

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

STANDARDS:

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

ADM-S SAFETY AND ACCIDENT PREVENTION

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

STANDARDS:

1. Discuss this patient's plan of care for safety based on the patient-specific risk assessment**. Refer to "FALL - Fall Prevention" on page 384.**

ADV - Advance Directives

ADV-I INFORMATION

OUTCOME: The patient/family will understand that an advance directive is either a living will or a Durable Power of Attorney for Health Care.

STANDARDS:

1. Explain that an advance directive is a written statement that is completed by the patient prior to mental deterioration, regarding how the patient wants medical decisions to be made.
2. Discuss the two most common forms of advance directives:
   a. Living will
   b. Durable Power of Attorney for Health Care
3. Explain that a patient may have both a living will and a durable power of attorney for healthcare.

ADV-L LITERATURE

OUTCOME: The patient/family will receive literature about advance directives.

STANDARDS:

1. Provide parent/family with literature on advance directives.
2. Discuss the content of the literature.

ADV-LW LIVING WILL

OUTCOME: The patient/family will understand living wills.

STANDARDS:

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

ADV-POA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

OUTCOME: The patient/family will understand Durable Power of Attorney for Health Care.

STANDARDS:

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

ADV-RI PATIENT RIGHTS AND RESPONSIBILITIES

OUTCOME: The patient/family will understand their rights and responsibilities regarding advance directives.

STANDARDS:

1. Explain the patient's right to accept, refuse, or withdraw from treatment, and the consequences of such actions.
2. Explain the patient's right to formulate an advance directive and appoint a surrogate to make healthcare decisions on the patient's behalf.
3. Explain that an advance directive may be changed or canceled by the patient at any time unless the patient has been declared legally incompetent. Any changes should be written, signed, and dated in accordance with state law, and copies should be given to the physician and others who received the original document.
4. Explain that it is the patient/family's responsibility to give a copy of the advance directive to the proxy, the healthcare provider, and to keep a copy in a safe place. An advance directive may be part of the patient's permanent medical record.

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-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving optimal physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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, e.g., 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, e.g., 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 the patient becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to "HPDP-EX Exercise" on page 480.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

AOL-IR INFORMATION AND REFERRAL

OUTCOME: The patient/family will receive information and referral for alternative or additional services as needed or desired.

STANDARDS:

1. Provide the patient/family with alternative or additional sources for care and services.
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

AOD-L LITERATURE

OUTCOME: The patient/family will receive literature on alcohol and other drugs.

STANDARDS:

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

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 that 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, e.g., 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-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
    a. Assessment of the nutrition related condition.
    b. Identification of the patient's nutritional problem.
    c. Identification of a specific nutrition intervention therapy plan.
    d. Evaluation of the patient's nutritional care outcomes.

e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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, the family, and the 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. Practicing self-hypnosis

k. Using positive imagery

l. Practicing relaxation methods such as deep breathing or progressive muscular relaxation

m. Participating in 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, e.g., 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, e.g., 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, e.g., food allergies; hay fever; allergy to mold, dander, and dust; drug allergies.
3. 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.
4. 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 healthcare and maintenance.

STANDARDS:

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

AN-L LITERATURE

OUTCOME: The patient/family will receive literature about allergy reactions.

STANDARDS:

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

AN-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

1. Assess the patient and family's level of acceptance of the disorder.
2. Review the lifestyle areas that may require adaptations, e.g., 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 MEDICATIONS

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 the signs of possible medication toxicity as indicated.
3. Emphasize the importance of taking the medications as prescribed.

AN-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understand of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
    a. Assessment of the nutrition related condition.
    b. Identification of the patient's nutritional problem.
    c. Identification of a specific nutrition intervention therapy plan.
    d. Evaluation of the patient's nutritional care outcomes.
    e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.

5. Refer to other providers or community resources as needed.

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 know, 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 a dietitian for assessment of nutritional needs and for appropriate treatment as indicated.

AL-TE TESTS

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

STANDARDS:

1. Explain that testing may be required to determine if the 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. Explain that history is important in diagnosing allergies, including whether the symptoms vary according to the time or the season and possible exposure that involve pets, diet changes, or other sources of allergens.
5. Explain that allergies may alter the results of some lab tests.

ALZ - Alzheimer's Disease

ALZ-ADV ADVANCE DIRECTIVE (FORMERLY LW)

OUTCOME: The patient/family/caregiver will understand the process of developing an advance directive and its role in maintaining a sense of control in the patient's medical care and decisions.

STANDARDS:

1. Explain that in most cases, patients with Alzheimer's disease will predictably lose the capacity to make their own decisions and an advance directive will be able to express the patient's desires prior to the loss of decision-making abilities.
2. Review the option of Advanced Directives/Living Will with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
3. Refer to appropriate services to assist the patient in making a living will, e.g., Social Services, Clergy, Lawyer.
4. **Refer to "ADV - Advance Directives" on page 40.**

ALZ-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of anatomy and physiology of the brain.

STANDARDS:

2. Explain normal anatomy and physiology of the brain.
3. Discuss the changes to anatomy/physiology as a result of Alzheimer's disease.
4. Discuss the impact of these changes on the patient's health or well-being.

ALZ-C COMPLICATIONS

OUTCOME: The patient/family will understand the effects and possible consequences as a result of Alzheimers.

STANDARDS:

1. Discuss the common or significant complications associated with the Alzheimers.
2. Discuss common or significant complications that may be prevented by full participation with the treatment regimen.
3. Discuss common or significant complications which may result from treatment(s).

ALZ-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving optimal physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33.**

ALZ-DP DISEASE PROCESS

OUTCOME: The patient/family/caregiver will understand Alzheimer's and treatment options available.

STANDARDS:

1. Explain that Alzheimer's disease is a degenerative brain disorder that destroys the chemical acetylcholine that is responsible for memory and cognitive skills. It is more common in older adults.
2. Explain that as the disease progresses, nerve cells in several brain areas shrink and die and the brain itself shrinks as the wrinkles along its surface become smoother.
3. Discuss the signs and symptoms and usual progression of the disease due to dementia (include any or all of the following as appropriate):
    a. Impaired memory and thinking
    b. Disorientation and confusion
    c. Misplacement of things
    d. Impaired abstract thinking
    e. Trouble performing familiar tasks
    f. Change in personality and behavior
    g. Poor or decreased judgment
    h. Inability to follow directions
    i. Problems with language or communication
    j. Impaired visual and spatial skills
    k. Loss of motivation or initiative

l. Loss of normal sleep patterns

m. Increasing agitation

n. Irrational violent behavior and lashing out

o. Late stage loss of ability to swallow

4. Explain that the cause is unknown and nothing can be done to prevent the disease. Encourage a healthy lifestyle and habits that prevent dementia (limit alcohol intake, stop smoking, eat well, exercise).
5. Discuss the importance of maintaining a positive mental attitude.

ALZ-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of Alzheimer's Disease.

STANDARDS:

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

ALZ-HM HOME MANAGEMENT

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

STANDARDS:

1. Explain the home management techniques necessary based on the status of the patient. Explain that these home management techniques may change as the disease progresses. Discuss ways to minimize confusion:
   a. Limit changes to the physical surroundings.
   b. Encourage full participation to daily routines.

c. Maintain orientation by reviewing the events of the day, date and time.

d. Simplify or reword statements.

e. Label familiar items/photos.

f. Follow simple routines

g. Avoid situations that require decision making

2. Explain that medications must be given as prescribed.
3. Explain the importance of being patient and supportive.
4. Discuss ways of providing a safe environment. **Refer to "ALZ-S Safety and Injury Prevention" on page 58**.
5. Explain the importance of supervising the patient during bathing and eating. Discourage leaving the patient alone for extended periods.
6. Encourage assistance with activities of daily living as appropriate.
7. Explain the benefits of increased physical activity (strength, endurance, heart fitness, increased energy, improvement in sleep, and mood and mental functioning). Advise family/caregiver to consult with a healthcare provider prior to beginning an exercise program for the patient. Explain that factors such as bone disease, heart condition, or balance problems may limit or restrict activities.
8. Encourage the patient to exercise the mind by reading, puzzles, writing, etc. as appropriate. Avoid challenging to the point of frustration.

ALZ-L LITERATURE

OUTCOME: The patient/family/caregiver will receive literature about Alzheimer's disease.

STANDARDS:

1. Provide parent/family/caregiver with literature on Alzheimer's disease.
2. Discuss the content of the literature.
3. Advise of any agency or organization that can provide assistance and further education, such as support groups.

ALZ-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

ALZ-LW LIVING WILL (REFER TO "ALZ-ADV Advance Directive (Formerly LW)" on page 52)

ALZ-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

ALZ-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand specific nutritional intervention(s) needed for treatment or management of Alzheimer's disease.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:

a. Assessment of the nutrition related condition.
b. Identification of the patient's nutritional problem.
c. Identification of a specific nutrition intervention therapy plan.
d. Evaluation of the patient's nutritional care outcomes.
e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ALZ-N NUTRITION

OUTCOME: The patient/family/caregiver will understand the need for optimal nutrition and feeding methods in Alzheimer's disease.

STANDARDS:

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

ALZ-PLC PLACEMENT

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

STANDARDS:

1. Explain the rationale for the recommended placement based on patient/family/ caregiver preference, level of need, involuntary placement, safety, eligibility, availability, and funding.

2. Explain that the purpose of placement is to ensure a safe and supportive environment for continued care.
3. Discuss alternative placement or treatment options if recommended placement is declined or unavailable.
4. Discuss patient/family/caregiver fears and concerns regarding placement and provide advocacy and support.

ALZ-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

1. Explain the importance of body mechanics in daily living to avoid injury, e.g., proper lifting techniques for lifting the patient as appropriate.
2. Discuss ways to adapt the home to improve safety and prevent injuries, e.g., remove throw rugs, install bars in tub/shower, secure electrical cords, install ramps.
3. Discuss mobility issues as appropriate.
4. Discuss the current/potential abuse of alcohol or drugs.
5. Discuss the need to secure medications and other potentially hazardous items.
6. Discuss fire hazards such as cooking, smoking in bed, or smoking unsupervised.
7. Discuss the potential for elder abuse/neglect (including financial exploitation) and ways to identify abuse/neglect. Refer as appropriate.
8. Explain the need to secure the patient's financial resources as they may be unable to make wise financial decisions.
9. Discuss that as the disease progresses, constant supervision will be necessary.
10. Discuss that patients may wander and alarms on doors, windows and beds may be necessary.

ALZ-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress can result in a worsened outcome for the patient, as well as, the caregiver.

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

ALZ-TE TESTS

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

STANDARDS:

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

ALZ-TX TREATMENT

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

STANDARDS:

1. Explain that there is no cure and it is important to maintain a positive mental attitude.
2. Explain the treatment plan. Emphasize the importance of active participation by the patient/family/caregiver in the development of the treatment plan.
3. Explain that regular visits to a healthcare provider are a crucial part of the treatment plan and the importance of starting treatment early to delay progression.
4. Explain that physical activity, good nutrition, a calm, safe, and structured environment, and social interaction are important for keeping Alzheimer's patients as functional as possible.
5. Explain that an appropriate drug regimen can sooth agitation, anxiety, depression, and sleeplessness and may help boost participation in daily activities.
6. Emphasize the importance of reassessing the level of daily functioning, mental status, mood, and emotional state of the patient. Discuss the importance of assessing the status of the caregiver(s).
7. **Refer to "EOL - End of Life" on page 372**.

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. In children anemia may result in impaired brain growth/development.
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.
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, vitamin C, 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
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 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 follow-up in the treatment of anemia.

STANDARDS:

1. Discuss the importance of follow-up care. Explain that follow-up appointments will be necessary to assess the effectiveness of the treatment.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

AN-L LITERATURE

OUTCOME: The patient/family will receive literature about anemia and its treatment.

STANDARDS:

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

AN-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication. Emphasize the importance of keeping iron out of the reach of children because an overdose of iron can be lethal.
2. Describe the name, strength, purpose, dosing directions, and storage of the medication.
3. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
4. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
5. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

AN-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of anemia.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
    a. Assessment of the nutrition related condition.
    b. Identification of the patient's nutritional problem.
    c. Identification of a specific nutrition intervention therapy plan.
    d. Evaluation of the patient's nutritional care outcomes.
    e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

AN-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition in treating anemia.

STANDARDS:

1. Explain that diet alone usually cannot treat anemia but plays an important role in therapy.
2. Encourage the patient to include foods rich in iron, such as lean meats, poultry, eggs, dried beans and peas, leafy green vegetables, in the diet.
3. Explain that ascorbic acid (vitamin C) helps the body absorb iron. Examples of vitamin C include citrus fruits, strawberries, broccoli, red and green peppers, tomatoes, and potatoes. If vitamin C supplementation is desirable, vitamin C and iron should be taken at the same time.
4. 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. Refer to a registered dietitian for MNT as appropriate.
5. 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, and alternatives to the proposed procedure(s).

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) (e.g., hemoglobin, hematocrit, iron studies, hemoglobin electrophoresis) in conjunction with a 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. Explain that periodically during treatment, blood counts must be obtained to assess the patient's degree of recovery.

AN-TX TREATMENT

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

STANDARDS:

1. Discuss the treatment for this patient's anemia. Explain that the treatment of severe anemia may include transfusions of red blood cells.
2. Explain that once the hemoglobin levels return to normal, therapy for iron-deficiency anemia should continue for the prescribed duration to replenish the body's depleted iron stores
3. Explain that some anemia cases require long-term or lifelong treatment and others may not be treatable.

ANS - Anesthesia

ANS-C COMPLICATIONS

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

STANDARDS:

1. Discuss the common and important complications of anesthesia**,** e.g., potential for death, disability, drug reaction, pain, nausea and vomiting, disorientation, as appropriate.
2. Advise the patient/family to report any unexpected symptoms, e.g., 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, the 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, e.g., 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 will 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 the 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 the 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 literature about anesthesia or anesthetics.

STANDARDS:

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

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 - Pain Management" on page 657.**
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 the 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 that 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 can 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 are nausea, vomiting, and diarrhea
    c. Allergic reactions
    d. Secondary infections, e.g., 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:
3. 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.
4. Antibiotic resistance occurs from exposure to an antibiotic when:
    a. 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.
    b. 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 for resistance to occur.
    c. 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.
5. 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.
    a. Discuss which illnesses are commonly caused by bacteria and require antibiotics including Streptococcal pharyngitis, pneumonia, ear, sinus, and urinary tract infections.
    b. 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 literature about antibiotic resistance, viral illnesses, or bacterial infections.

STANDARDS:

1. Provide the patient/family with literature on antibiotic resistance, viral illnesses, or bacterial infections.
2. Discuss the content of the literature.

ABX-M MEDICATIONS

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 exactly follow the directions for duration of therapy and doses per day 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 (e.g., sinus infections, community acquired pneumonia, strep throat) and sensitivity testing may not be required.
5. Explain that serious infections like hospital acquired pneumonia and recurrent infections may require culture and antibiotic sensitivity testing to select the appropriate treatment.
6. When appropriate, discuss that not all types of bacteria may be cultured and that additional antibiotics may have to be used to treat anaerobic bacteria.

ACC - Anticoagulation

ACC-C COMPLICATIONS

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

STANDARDS:

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

ACC-DP DISEASE PROCESS

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

STANDARDS:

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

ACC-FU FOLLOW-UP

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

STANDARDS:

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

ACC-HM HOME MANAGEMENT

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

STANDARDS:

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

ACC-L LITERATURE

OUTCOME: The patient/family will receive literature regarding anticoagulation therapy.

STANDARDS:

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

ACC-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

ACC-M MEDICATIONS

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

STANDARDS:

1. Discuss the use and mechanism of action of anticoagulants.

2. Explain the duration of anticoagulant therapy and the necessity of regular blood tests.
3. Discuss the methods of medication administration and directions of use.
4. Discuss the expected benefits of therapy as well as the important and common side effects.
5. Emphasize that the patient should avoid activities that could increase the risk of injury while taking anticoagulants.
6. Discuss side effects, such as unexpected bleeding, that should prompt an immediate return visit.
7. Discuss that some anticoagulants can cause birth defects. Emphasize the importance of contraception.
8. Discuss the importance of consulting a physician if breastfeeding.
9. Explain the common and important interactions with anticoagulant therapy including food, drug, over-the-counter medications, vitamins, and herbal preparations.
10. Emphasize the importance of full participation with the medication/treatment plan.
11. Explain the importance of follow-up in monitoring the effects of anticoagulants.

ACC-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ACC-N NUTRITION

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

STANDARDS:

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

ACC-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

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

ACC-TE TESTS

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

STANDARDS:

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

ASM - Asthma

ASM- AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to asthma.

STANDARDS:

1. Explain normal anatomy and physiology of the lungs.
2. Discuss the changes to anatomy and physiology as a result of asthma.
3. Discuss the impact of these changes on the patient's health or well-being.

ASM-C COMPLICATIONS

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

STANDARDS:

1. Discuss the most common complications of asthma are exacerbation or infection. These complications often result from exposure to environmental triggers, infections, or failure to fully participate with treatment plan (e.g., medications, peak flows).
2. Emphasize early medical intervention for respiratory illnesses can reduce the risk of complications, hospitalizations and ER visits.

ASM-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in asthma.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

ASM-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 the disease processes may be influenced by choices related to health and lifestyles, e.g., diet, exercise, sleep, stress management, hygiene, full participation in the medical plan. (Stoic Fatalism)
2. Discuss that traditions, such as sweat lodges, cultural/traditional smoking practices, may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
3. Explain that traditional medicines/treatments should be reviewed with the healthcare 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.

ASM-DP DISEASE PROCESS

OUTCOME: The patient will understand the pathophysiology of asthma.

STANDARDS:

1. Review the anatomy and physiology of the respiratory system.
2. Discuss common triggers of asthma attacks, e.g., 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, e.g., nasal allergy, eczema. Explain that control of these concomitant illnesses may be necessary to control the asthma.

ASM-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the indication for and benefits of prescribed home medical equipment.
2. Demonstrate the proper use and care of medical equipment, as appropriate.
3. Discuss infection control principles as appropriate.
4. **Refer to "ASM-NEB Nebulizer" on page 83, "ASM-PF Peak-Flow Meter" on page 83, "ASM-MDI Metered-Dose Inhalers" on page 82,** and **"ASM-SPA Spacers" on page 85 as appropriate.**

ASM-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in asthma.

STANDARDS:

1. Discuss the benefits of any exercise program. Explain that exercise should be consistent and of sufficient duration to obtain the desired outcome.
2. Assist the patient in developing a personal exercise plan.
3. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
4. Discuss medical clearance issues for physical activity.
5. Refer to community resources as appropriate.
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/family will understand the importance of follow-up in the treatment of asthma.

STANDARDS:

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

3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.
6. 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/ family will understand home management of asthma.

STANDARDS:

1. Discuss home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, e.g., 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 (e.g., cigarette smoke, stress, environmental smoke, pollen, mold, dust, roaches, insecticides, paint fumes, perfumes, animal dander, cold air, sulfites, and NSAIDs) as appropriate.

ASM-L LITERATURE

OUTCOME: The patient/family will receive literature about asthma.

STANDARDS:

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

ASM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle adaptations necessary to prevent complications of asthma.

STANDARDS:

1. Discuss lifestyle changes within the patient's control: e.g., cessation of smoking, dietary modifications, weight control, treatment participation, and exercise. Refer to available community resources.
2. Emphasize the need for identification and environmental triggers (e.g., cigarette smoke, stress, environmental smoke, pollen, mold, dust, roaches, insecticides, paint fumes, perfumes, animal dander, cold air, sulfites, and NSAIDs) as appropriate. Discuss the remediation and removal of identified indoor triggers.

ASM-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.

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 Spacers" on page 85.**

ASM-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family understand the specific nutritional intervention(s) needed for treatment or management of asthma.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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 for MNT as appropriate.

ASM-NEB NEBULIZER

OUTCOME: The patient will be able to demonstrate effective use of the nebulizer.

STANDARDS:

1. Describe proper use of the nebulizer including preparation of the inhalation mixture, inhalation technique, and care of equipment.

ASM-PF PEAK-FLOW METER

OUTCOME: The patient will be able to demonstrate correct use of the peak-flow meter.

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.

2. Discuss peak flow zones as an objective way to determine current respiratory function and manage airway disease.
3. Emphasize that regular monitoring 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.

ASM-SHS SECOND-HAND SMOKE

OUTCOME: The patient/family will understand the adverse health consequences associated with exposure to second-hand tobacco smoke.

STANDARDS:

1. Define "passive smoking" and ways in which exposure occurs, e.g., smoldering tobacco, exhaled smoke, residue in carpet.
2. Discuss harmful substances in smoke e.g., nicotine, benzene, CO, carcinogens.
3. Explain the increased risk of illness in children and adults when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia, lung cancer.
4. Discuss that having household members smoke outside and removing smoke contaminated clothing may decrease exposure to second hand smoke.
5. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness.
6. Encourage smoking cessation or at least never smoking in the home or car. **Refer to "TO-QT Quit" on page 832.**

ASM-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in asthma.

STANDARDS:

1. Explain that uncontrolled stress may exacerbate asthma.
2. Discuss various stress management strategies such as maintaining a healthy lifestyle. Some examples may include:
   a. Becoming aware of your own reactions to stress
   b. Recognizing and accepting your limits
   c. Talking with people you trust about your worries or problems

d. Setting realistic goals
e. Getting enough sleep
f. Maintaining a healthy diet
g. Exercising regularly
h. Taking vacations
i. Practicing meditation, self-hypnosis, and positive imagery
j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
k. Participating in spiritual or cultural activities

3. Provide referrals as appropriate.

ASM-SPA SPACERS

OUTCOME: The patient/family 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.

STANDARDS:

1. Explain the test ordered and collection method.
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 and instructions 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.

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. **Refer to "TO - Tobacco Use" on page 828**.

ASM-TX TREATMENT

OUTCOME: The patient/family will understand the treatment of asthma.

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, pharmacotherapy, environmental control, peak flow use, cultural practices, and psychosocial aspects.
3. Discuss the importance of adhering to the treatment plan, including scheduled follow-up.
4. Refer to community resources as appropriate.

ADD - Attention Deficit Hyperactivity Disorder

ADD-C COMPLICATIONS

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

STANDARDS:

1. Discuss that ADD/ADHD often co-exists with other psychiatric diagnoses.
2. Discuss that dysfunctional family dynamics often exists in the homes of persons with ADD/ADHD.
3. Discuss that growth delay is often a problem with treated and untreated ADD/ ADHD and may require intervention by a registered dietician.
4. Discuss that persons with ADD/ADHD are at increased risk of injuries.
5. Discuss that persons with ADD/ADHD often have problems with learning and behavior at school and other organized activities.

ADD-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving optimal physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

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 Nutrition" on page 90**.

ADD-L LITERATURE

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

STANDARDS:

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

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 MEDICATIONS

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-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for the treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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

ATO - Autoimmune Disorders

ATO-C COMPLICATIONS

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

STANDARDS:

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

ATO-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the patient's particular autoimmune disease.

STANDARDS:

1. Discuss the effects of the autoimmune disorder.
2. Explain that treatments are highly individualized and may vary over the course of the disease.
3. Explain that outcome varies with the specific disorder. Most are chronic, but many can be controlled with treatment.
4. Explain that symptoms of autoimmune disease vary widely depending on the type of disease. A group of non-specific symptoms often accompany autoimmune disease. Review these symptoms with the patient.
    a. Tire easily
    b. Fatigue
    c. Dizziness
    d. Malaise
    e. Low grade temperature elevations

ATO-FU FOLLOW-UP

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

STANDARDS:

1. Review the treatment plan with the patient/family, emphasizing the need for keeping appointments, taking medications as prescribed, and fully participating with the treatment plan.
2. Discuss the importance of routine follow-up by the primary provider, social services, behavioral health services, registered dietician, and community health services. Refer as appropriate.
3. Review the symptoms that should be reported and measures to take if they occur.

ATO-L LITERATURE

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

STANDARDS:

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

ATO-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

1. Review the lifestyle areas that may require adaptations: diet, physical activity, sexual activity, role changes, communication skills and interpersonal relationships.
2. Refer to social services, behavioral health, and community services as appropriate.

ATO-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.

4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

ATO-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for treatment or management of autoimmune disorder.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ATO-N NUTRITION

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

STANDARDS:

1. Explain the keeping a food diary is beneficial to determine nutritional habits and intake.
2. Explain that some autoimmune diseases may improve or worse with changes in diet.
3. Explain that many patients with autoimmune diseases will have altered nutritional requirements and will require a nutritional plan. Refer to a registered dietitian for MNT as appropriate.

ATO-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in if autoimmune disorder.

STANDARDS:

1. Explain that uncontrolled stress can suppress the immune response.
2. Explain that uncontrolled stress can interfere with the treatment of autoimmune disorders.
3. Explain that effective stress management may increase the number of immune cells, as well as help improve the patient's health and well-being.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality from autoimmune disorders.
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 healthy diet
    g. Exercising regularly
    h. Taking vacations
    i. Practicing meditation, self-hypnosis, and positive imagery
    j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    k. Participating in spiritual or cultural activities
6. Provide referrals as appropriate.

ATO-TE TESTS

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

STANDARDS:

1. Explain the test(s) ordered and collection method.

2. Explain the necessity, benefits, and risks of the test(s) to be performed and how it relates to the course of treatment.
3. Explain any necessary preparation and instructions for the test(s), e.g., fasting.
4. Explain the meaning of the test results, as appropriate.

ATO-TX TREATMENT

OUTCOME: The patient/family will understand the available treatments.

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.
3. Emphasize the importance of adhering to the treatment plan, including scheduled follow-up.
4. Refer to community resources as appropriate.

B

BH - Behavioral and Social Health

BH-ADL ACTIVITIES OF DAILY LIVING

OUTCOME: The patient/family will understand how the patient's ability to perform activities of daily living (ADLs) impact the care plan including in-home and out-of-home care.

STANDARDS:

1. Define activities of daily living (ADLs) (e.g., the everyday activities involved in personal care such as feeding, dressing, bathing, moving from a bed to a chair (also called transferring), toileting, and walking) and discuss how the patient's ability to perform ADLs affects their ability to live independently.
2. Assist the patient/family in assessing the patient's ability to perform activities of daily living.
3. Provide the appropriate information and referrals for services needed to increase, maintain, and/or assist with activities of daily living.

BH-ANA ABUSE AND NEGLECT – ADULT

OUTCOME: The patient/family will understand the definitions and warning signs of adult abuse and neglect and be aware of available medical treatment and social services for victims.

STANDARDS:

1. Discuss and define the different types of adult abuse and neglect including emotional, physical, and sexual.
2. Emphasize the importance of reporting suspected incidents of adult abuse and neglect to the patient's healthcare provider and the proper adult protective and law enforcement agencies.
3. Discuss patient rights to privacy and confidentiality as it relates to patient/family safety and mandatory reporting laws for providers, as appropriate.
4. Identify methods and resources to enhance patient safety while maintaining the patient's autonomy and independence as appropriate.

BH-ANC ABUSE AND NEGLECT – CHILD

OUTCOME: The patient/family will understand the definitions and warning signs of child abuse and neglect and be aware of reporting requirements and the availability of immediate medical care and welfare/protective services.

STANDARDS:

1. Discuss and define the different types of child abuse and neglect including emotional, physical, and sexual.
2. Emphasize the importance of reporting suspected incidents of child abuse and neglect to the proper law enforcement and child welfare/protective agencies and the patient's healthcare provider.
3. Discuss patient rights to privacy and confidentiality as it relates to patient/family safety and mandatory reporting laws for providers.
4. Emphasize the importance of securing appropriate medical care, behavioral health and social services for victims of child abuse and their families with an emphasis on immediate safety and medical needs of the victim.

BH-CM CASE MANAGEMENT

OUTCOME: The patient/family will understand the importance of integrated case management in achieving optimal behavioral health.

STANDARDS:

1. Discuss the roles and responsibilities of each member of the care team including the patient, family, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33.**

BH-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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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.

BH-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the process of a behavioral health diagnosis or issue and develop a plan to participate in treatment.

STANDARDS:

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

BH-EX EXERCISE

OUTCOME: The patient will understand the importance of increased physical activity in order to attain optimal behavioral health and wellness.

STANDARDS:

1. Explain that moderate physical activity may increase energy, improve circulation, enhance sleep, and reduce stress and depression.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:

a. 30 minutes 5 days per week
b. 15 minutes bouts 2 times a day 5 days per week
c. 10 minutes bouts 3 times a day 5 days per week

3. Encourage the patient to increase the intensity of the activity as the patient becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to "HPDP-EX Exercise" on page 480.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

BH-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care to achieving the goals in the care plan.
2. Discuss the procedure for obtaining follow-up appointments.
3. Provide information about transportation assistance for follow-up appointments if needed and if available at your institution.

BH-HOU HOUSING

OUTCOME: The patient/family will understand the relationship between adequate and safe housing and optimal health and the options available for emergency shelter and/or affordable housing.

STANDARDS:

1. Provide the patient/family with current information on the availability of shelter services and/or affordable housing or housing assistance (e.g., subsidized housing, emergency rental assistance).
2. Provide the patient/family with assistance and advocacy as needed when attempting to secure shelter or housing services.

BH-IR INFORMATION AND REFERRAL

OUTCOME: The patient/family will receive information and referral for alternative or additional services as needed or desired.

STANDARDS:

1. Provide the patient/family with alternative or additional sources for care and services.
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

BH-L LITERATURE

OUTCOME: The patient/family will receive literature about behavioral health issue(s).

STANDARDS:

1. Provide patient/family with appropriate literature and/or Website addresses to facilitate understanding and knowledge of behavioral health issues.
2. Discuss the content of the literature.

BH-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of medication management.

STANDARDS:

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

BH-PLC PLACEMENT

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

STANDARDS:

1. Explain the rationale for the recommended placement based on patient/family preference, level of need, involuntary placement, safety, eligibility, availability and funding.
2. Explain that the purpose of placement is to improve mental or physical health and to ensure a safe and supportive environment for continued healing.
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.

BH-RI PATIENT RIGHTS AND RESPONSIBILITIES

OUTCOME: The patient/family will understand patient rights and responsibilities.

STANDARDS:

1. Explain to the patient/family their rights and responsibilities.
2. Discuss patient's rights to privacy and confidentiality with exceptions for patient safety and harm to self/harm to others as appropriate.
3. Explain to the patient/family the process for addressing conflict resolution and grievance.

BH-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in mood disorders and behavioral health issues.

STANDARDS:

1. Explain that uncontrolled stress is linked with the onset and exacerbation of behavioral health issues.
2. Explain that uncontrolled stress can interfere with the treatment of behavioral health issues.

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. Emphasize the importance of seeking professional help as needed to reduce stress.
5. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other drug (AOD) use as well as inappropriate eating, all of which may increase the severity of anxiety and increase the risk of depression and harm to self and/or harm to others.
6. Discuss various stress management strategies which promote 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 meaningful and measurable goals
   e. Getting enough sleep
   f. Making healthy food choices
   g. Regular physical activity
   h. Taking vacations
   i. Practicing meditation
   j. Practicing self-hypnosis
   k. Using positive imagery
   l. Practicing relaxation methods such as deep breathing or progressive muscular relaxation
   m. Participating in spiritual or cultural activities
7. Provide referrals as appropriate.

BH-TE TEST/SCREENING

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

STANDARDS:

1. Explain the test/screening ordered and any necessary consent as needed.
2. Explain the indications, benefits and risks of the test/screening to be performed, as appropriate, including the consequences of refusal.
3. Explain how the test/screening relates to the course of treatment.

4. Explain the necessary preparation for the test/screening, including appropriate collection or preparation.
5. Explain the meaning of the test/screening results, as appropriate, and the implications for care.

BH-TH THERAPY

OUTCOME: The patient/family will understand the goals and process of therapy

STANDARDS:

1. Review the reason for the initial referral for therapy as part of the care plan.
2. Explain that therapy may include individual, group, psycho-educational/ therapeutic, talking circles, or other modalities.
3. Explain that the therapist and the patient will jointly establish the treatment method, frequency and duration, treatment guidelines, and goals and objectives.
4. Emphasize that for therapy to be successful the patient/family must fully participate with the treatment plan.

BH-TLM TELE-MENTAL HEALTH

OUTCOME: The patient/family will be aware of the option of receiving tele-mental health.

STANDARDS:

1. Explain that tele-mental health services are an alternative to face-to-face care when the patient/family lives in a geographically remote area or the needed service does not exist locally.
2. Explain the risks and benefits of the service offered and informed consent must be obtained. Explain that patients are fee to refuse tele-mental health services; however, there may not be any other services available.
3. Discuss the process of tele-mental health including the use of telecommunication equipment, the role of the distant consulting clinician and the proximate treating clinician and the plans for clinical management (e.g., level of support at the originating site, where prescriptions can be filled, and emergency services if needed.).

BH-TR TRANSPORTATION

OUTCOME: The patient/family will understand the options available to them in securing reliable, affordable and accessible transportation in order to keep healthcare and other appointments.

STANDARDS:

1. Provide the patient/family with information regarding transportation options which may include transportation covered by insurance, public, handicap accessible, and tribal or other community transportation services.
2. Assist the patient/family in determining eligibility requirements, obtaining and completing applications and securing documentation as needed to attain transportation services.

BH-WL WELLNESS

OUTCOME: The patient/family will understand the behaviors and lifestyle choices that contribute to wellness.

STANDARDS:

1. Explain healthy food choices are an important component of behavioral and emotional health. **Refer to "HPDP-N Nutrition" on page 483.**
2. Emphasize the importance of stress reduction and increased physical activity in behavioral and emotional health.
3. Discuss that behavioral and emotional problems may result from unhealthy patterns of social interaction.
4. Emphasize that the use of alcohol and other drugs (AOD) can be extremely harmful to behavioral and emotional health.
5. Encourage the patient/family to identify and participate in healthy family, social, cultural, and community activities.
6. Provide the patient/family with appropriate patient information and referrals to obtain further information and services in order to make healthy choices and promote wellness.

BELL - Bell's Palsy

BELL-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

BELL-C COMPLICATIONS

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

STANDARDS:

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

BELL-DP DISEASE PROCESS

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

STANDARDS:

1. Explain that Bell's palsy can strike almost anyone at any age, but it is less common before age 15 and after age 60. Explain that it is more common in persons with diabetes, influenza, a cold or upper respiratory ailment, and pregnancy.
2. Explain that the common cold sore virus, herpes simplex, and other herpes viruses cause many cases of Bell's palsy, but Bell's palsy can also be caused by other infections especially tick fevers.

3. Explain that pain behind the ear may precede facial weakness and that weakness may progress to complete unilateral facial paralysis within hours. This paralysis may cause a drooping eyelid, inability to blink, drooping mouth, drooling, dryness of the eye or mouth, impaired taste, and excessive tearing. Explain that in severe cases the eye may not close and that salivation, taste and lacrimation may be affected.
4. Discuss that the prognosis for Bell's palsy is generally very good. Explain that about 80% recover completely within 3 months, but that for some the symptoms may last longer and may never completely disappear. Explain that the recovery for complete paralysis takes longer and that there is an increased incidence of residual symptoms.
5. Discuss that during the recovery period regrowth of nerve fibers may result in tearing while eating and unexpected muscle contractions during voluntary facial movements.

BELL-FU FOLLOW-UP

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

STANDARDS:

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

BELL-L LITERATURE

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

STANDARDS:

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

BELL-M MEDICATIONS

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

STANDARDS:

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

BELL-PM PAIN MANAGEMENT

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

STANDARDS:

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

BELL-TE TESTS

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

STANDARDS:

1. Explain that chest and skull x-rays, CT and/or MRI scans may be necessary to rule out other serious causes of facial paralysis.

2. Explain that tests for tick fever may also help diagnose the cause of the palsy and may be necessary to guide appropriate treatment.
3. Explain that nerve conduction studies and electromyography may be ordered to determine the extent of the nerve damage.
4. Explain the specific test ordered.
5. Explain the necessity, benefits, and risks of the test to be performed, and how it relates to the course of treatment.
6. Explain any necessary preparation for the test ordered.
7. Explain the meaning of the test results, as appropriate.

BELL-TX TREATMENT

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

STANDARDS:

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

BWP - Biological Weapons

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

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

BWP-C COMPLICATIONS

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

STANDARDS:

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

BWP-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.

5. Discuss that traditions, such as sweat lodges, may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

BWP-DP DISEASE PROCESS

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

STANDARDS:

1. Discuss the current information about the suspected biological weapon including the time-course, clinical features, and pathophysiology.
2. Discuss the signs/symptoms and usual progression of the suspected biological weapon.
   a. **Anthrax:** The incubation period is generally 1–6 days, although longer periods have been noted. Fever, malaise, fatigue, cough and mild chest discomfort progresses to severe respiratory distress with dyspnea, diaphoresis, stridor, cyanosis, and shock. Death typically occurs within 24–36 hours after onset of severe symptoms. Anthrax presents three somewhat distinct clinical syndromes in humans: cutaneous, inhalational, and gastrointestinal disease. The cutaneous form (also referred to as a malignant pustule) occurs most frequently on the hands and forearms of persons working with infected livestock. It begins as a papule followed by formation of a fluid-filled vesicle. The vesicle typically dries and forms a coal-black scab (eschar), hence the term anthrax (from the Greek for coal). This local infection can occasionally disseminate into a fatal systemic infection. Gastrointestinal anthrax is rare in humans and is contracted by the ingestion of insufficiently cooked meat from infected animals. Endemic inhalational anthrax, known as Woolsorters' disease, is also a rare infection contracted by inhalation of the spores. It occurs mainly among workers in an industrial
   b. **Brucellosis:** Brucellosis has a low mortality rate (5% of untreated cases), with rare deaths caused by endocarditis or meningitis. Also, given that the disease has a relatively long and variable incubation period (5–60 days), and that many naturally occurring infections are asymptomatic, its usefulness as a weapon may be diminished. Large aerosol doses, however, may shorten the incubation period and increase the clinical attack rate, and the disease is relatively prolonged, incapacitating, and disabling in its natural form. Brucellosis, also known as "undulant fever," typically presents as a nonspecific febrile illness resembling influenza. Fever, headache, myalgias, arthralgias, back pain, sweats, chills, generalized weakness, and malaise are common complaints. Cough and pleuritic chest pain occurs in up to 20 percent of cases, but acute

pneumonitis is unusual, and pulmonary symptoms may not correlate with radiographic findings. The chest x-ray is often normal, but may show lung abscesses, single or miliary nodules, bronchopneumonia, enlarged hilar lymph nodes, and pleural effusions. Gastrointestinal symptoms (anorexia, nausea, vomiting, diarrhea and constipation) occur in up to 70 percent of adult cases, but less frequently in children. Ileitis, colitis, and granulomatous or mononuclear infiltrative hepatitis may occur, with hepato- and splenomegaly present in 45–63 percent of cases. Lumbar pain and tenderness can occur in up to 60% of brucellosis cases and are sometimes due to various osteoarticular infections of the axial skeleton. Vertebral osteomyelitis, intervertebral disc space infection, paravertebral abscess, and sacroiliac infection occur in a minority of cases, but may be a cause of chronic symptoms. Consequently, persistent fever following therapy or the prolonged presence of significant musculoskeletal complaints should prompt CT or MR imaging. 99m Technetium and 67 Gallium scans are also reasonably sensitive means for detecting sacroiliitis and other axial skeletal infections. Joint involvement in brucellosis may vary from pain to joint immobility and effusion. While the sacroiliac joints are most commonly involved, peripheral joints (notably, hips, knees, and ankles) may also be affected. Meningitis complicates a small minority of brucellosis cases, and encephalitis, peripheral neuropathy, radiculoneuropathy and meningovascular syndromes have also been observed in rare instances. Behavioral disturbances and psychoses appear to occur out of proportion to the height of fever, or to the amount of overt CNS disease. This raises questions about an ill-defined neurotoxic component of brucellosis.

c. **Glanders and Melioidosis:** Incubation period ranges from 10–14 days after inhalation. Onset of symptoms may be abrupt or gradual. Inhalational exposure produces fever (common in excess of 102°F), rigors, sweats, myalgias, headache, pleuritic chest pain, cervical adenopathy, hepatosplenomegaly, and generalized papular / pustular eruptions. Acute pulmonary disease can progress and result in bacteremia and acute septicemic disease. Both diseases are almost always fatal without treatment. Both glanders and melioidosis may occur in an acute localized form, as an acute pulmonary infection, or as an acute fulminant, rapidly fatal, sepsis. Combinations of these syndromes may occur in human cases. Also, melioidosis may remain asymptomatic after initial acquisition, and remain quiescent for decades. However, these patients may present with active melioidosis years later, often associated with an immune-compromising state. Aerosol infection produced by a BW weapon containing either B. mallei or B. pseudomallei could produce any of these syndromes. The incubation period ranges from 10–14 days, depending on the inhaled dose and agent virulence. The septicemic form begins suddenly with fever, rigors, sweats, myalgias, pleuritic chest pain, granulomatous or necrotizing lesions, generalized erythroderma, jaundice, photophobia, lacrimation, and diarrhea. Physical examination may reveal fever, tachycardia, cervical adenopathy and mild hepatomegaly or splenomegaly. Blood cultures are usually negative until the patient is moribund. Mild leukocytosis with a shift to the left or leukopenia may occur. The pulmonary form may follow inhalation or arise by

hematogenous spread. Systemic symptoms as described for the septicemic form occur. Chest radiographs may show miliary nodules (0.5–1.0 cm) and/or a bilateral bronchopneumonia, segmental, or lobar pneumonia, consolidation, and cavitating lung lesions. Acute infection of the oral, nasal, and/ or conjunctival mucosa can cause mucopurulent, blood-streaked discharge from the nose, associated with septal and turbinate nodules and ulcerations. If systemic invasion occurs from mucosal or cutaneous lesions then a papular and / or pustular rash may occur that can be mistaken for smallpox (another possible BW agent). Evidence of dissemination of these infections includes the presence of skin pustules, abscesses of internal organs, such as liver and spleen, and multiple pulmonary lesions. This form carries a high mortality, and most patients develop rapidly progressive septic shock. The chronic form is unlikely to be present within 14 days after a BW aerosol attack. It is characterized by cutaneous and intramuscular abscesses on the legs and arms. These lesions are associated with enlargement and induration of the regional lymph channels and nodes. The chronic form may be asymptomatic, especially with melioidosis. There have been cases associated with the development of steomyelitis, brain abscess, and meningitis.

d. **Plague:** Pneumonic plague begins after an incubation period of 1–6 days, with high fever, chills, headache, malaise, followed by cough (often with hemoptysis), progressing rapidly to dyspnea, stridor, cyanosis, and death. Gastrointestinal symptoms are often present. Death results from respiratory failure, circulatory collapse, and a bleeding diathesis. Bubonic plague, featuring high fever, malaise, and painful lymph nodes (buboes) may progress spontaneously to the septicemic form (septic shock, thrombosis, DIC) or to the pneumonic form. Plague normally appears in three forms in man: bubonic, septicemic, and pneumonic. The bubonic form begins after an incubation period of 2–10 days, with acute and fulminant onset of nonspecific symptoms, including high fever, malaise, headache, myalgias, and sometimes nausea and vomiting. Up to half of patients will have abdominal pain. Simultaneous with or shortly after the onset of these nonspecific symptoms, the bubo develops – a swollen, very painful, infected lymph node. Buboes are normally seen in the femoral or inguinal lymph nodes as the legs are the most commonly flea-bitten part of the adult human body. The liver and spleen are often tender and palpable. One quarter of patients will have various types of skin lesions: a pustule, vesicle, eschar or papule (containing leukocytes and bacteria) in the lymphatic drainage of the bubo, and presumably representing the site of the inoculating flea bite. Secondary septicemia is common, as greater than 80 percent of blood cultures are positive for the organism in patients with bubonic plague. However, only about a quarter of bubonic plague patients progress to clinical septicemia. In those that do progress to secondary septicemia, as well as those presenting septicemic but without lymphadenopathy (primary septicemia), the symptoms are similar to other Gram-negative septicemias: high fever, chills, malaise, hypotension, nausea, vomiting, and diarrhea. However, plague septicemia can also produce thromboses in the acral vessels, with necrosis and gangrene, and DIC. Black necrotic appendages and more

proximal purpuric lesions caused by endotoxemia are often present. Organisms can spread to the central nervous system, lungs, and elsewhere. Plague meningitis occurs in about 6% of septicemic and pneumonic cases. Pneumonic plague is an infection of the lungs due to either inhalation of the organisms (primary pneumonic plague), or spread to the lungs from septicemia (secondary pneumonic plague). After an incubation period varying from 1 to 6 days for primary pneumonic plague (usually 2–4 days, and presumably dose-dependent), onset is acute and often fulminant. The first signs of illness include high fever, chills, headache, malaise, and myalgias, followed within 24 hours by a cough with bloody sputum. Although bloody sputum is characteristic, it can sometimes be watery or, less commonly, purulent. Gastrointestinal symptoms, including nausea, vomiting, diarrhea, and abdominal pain, may be present. Rarely, a cervical bubo might result from an inhalational exposure. The chest X-ray findings are variable, but most commonly reveal bilateral infiltrates, which may be patchy or consolidated. The pneumonia progresses rapidly, resulting in dyspnea, stridor, and cyanosis. The disease terminates with respiratory failure, and circulatory collapse. Nonspecific laboratory findings include a leukocytosis, with a total WBC count up to 20,000 cells with increased bands, and greater than 80 percent polymorphonuclear cells. One also often finds increased fibrin split products in the blood indicative of a low-grade DIC. The BUN, creatinine, ALT, AST, and bilirubin may also be elevated, consistent with multi-organ failure. In man, the mortality of untreated bubonic plague is approximately 60 percent (reduced to <5% with prompt effective therapy), whereas in untreated pneumonic plague the mortality rate is nearly 100 percent, and survival is unlikely if treatment is delayed beyond 18 hours of infection. In the U.S. in the past 50 years, 4 of the 7 pneumonic plague patients (57%) died. Recent data from the ongoing Madagascar epidemic, which began in 1989, corroborate that figure; the mortality associated with respiratory involvement was 57%, while that for bubonic plague was 15%.

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

absence of pulmonary signs and symptoms. Uncommon complications include chronic hepatitis, culture-negative endocarditis, aseptic meningitis, encephalitis and osteomyelitis. Most patients who develop endocarditis have pre-existing valvular heart disease.

f. **Tularemia:** Ulceroglandular tularemia presents with a local ulcer and regional lymphadenopathy, fever, chills, headache and malaise. Typhoidal tularemia presents with fever, headache, malaise, substernal discomfort, prostration, weight loss and a non-productive cough. After an incubation period varying from 1–21 days (average 3–5 days), presumably dependent upon the dose of organisms, onset is usually acute. Tularemia typically appears in one of six forms in man depending upon the route of inoculation: typhoidal, ulceroglandular, glandular, oculoglandular, oropharyngeal, and pneumonic tularemia. In humans, as few as 10 to 50 organisms will cause disease if inhaled or injected intradermally, whereas approximately 10 organisms are required with oral challenge. Typhoidal tularemia (5–15 percent of naturally acquired cases) occurs mainly after inhalation of infectious aerosols, but can occur after intradermal or gastrointestinal challenge. F. tularensis would presumably be most likely delivered by aerosol in a BW attack and would primarily cause typhoidal tularemia. It manifests as fever, prostration, and weight loss, but unlike most other forms of the disease, presents without lymphadenopathy. Pneumonia may be severe and fulminant and can be associated with any form of tularemia (30% of ulceroglandular cases), but it is most common in typhoidal tularemia (80% of cases). Respiratory symptoms, substernal discomfort, and a cough (productive and non-productive) may also be present. Case fatality rates following a BW attack may be greater than the 1–3% seen with appropriately treated natural disease. Case fatality rates are about 35% in untreated naturally acquired typhoidal cases. Ulceroglandular tularemia (75–85 percent of cases) is most often acquired through inoculation of the skin or mucous membranes with blood or tissue fluids of infected animals. It is characterized by fever, chills, headache, malaise, an ulcerated skin lesion, and painful regional lymphadenopathy. The skin lesion is usually located on the fingers or hand where contact occurs. Glandular tularemia (5–10 percent of cases) results in fever and tender lymphadenopathy but no skin ulcer. Oculoglandular tularemia (1–2 percent of cases) occurs after inoculation of the conjunctivae by contaminated hands, splattering of infected tissue fluids, or by aerosols. Patients have unilateral, painful, purulent conjunctivitis with preauricular or cervical lymphadenopathy. Chemosis, periorbital edema, and small nodular lesions or ulcerations of the palpebral conjunctiva are noted in some patients. Oropharyngeal tularemia refers to primary ulceroglandular disease confined to the throat. It produces an acute exudative or membranous pharyngotonsillitis with cervical lymphadenopathy. Pneumonic tularemia is a severe atypical pneumonia that may be fulminant and with a high case fatality rate if untreated. It can be primary following inhalation of organisms or secondary following hematogenous / septicemic spread. It is seen in 30-80 percent of the typhoidal cases and in 10–15 percent of the ulceroglandular cases. The case fatality rate without treatment is approximately 5 percent for

the ulceroglandular form and 35 percent for the typhoidal form. All ages are susceptible, and recovery is generally followed by permanent immunity.

g. **Smallpox:** Clinical manifestations begin acutely with malaise, fever, rigors, vomiting, headache, and backache. 2–3 days later lesions appear which quickly progress from macules to papules, and eventually to pustular vesicles. They are more abundant on the extremities and face, and develop synchronously. The incubation period of smallpox averaged 12 days, although it could range from 7–19 days following exposure. Clinical manifestations begin acutely with malaise, fever, rigors, vomiting, headache, and backache; 15% of patients developed delirium. Approximately 10% of light-skinned patients exhibited an erythematous rash during this phase. Two to three days later, an enanthem appears concomitantly with a discrete rash about the face, hands, and forearms. Following eruptions on the lower extremities, the rash spread centrally to the trunk over the next week. Lesions quickly progressed from macules to papules, and eventually to pustular vesicles. Lesions were more abundant on the extremities and face, and this centrifugal distribution is an important diagnostic feature. In distinct contrast to varicella, lesions on various segments of the body remain generally synchronous in their stages of development. From 8 to 14 days after onset, the pustules form scabs that leave depressed depigmented scars upon healing. Although variola concentrations in the throat, conjunctiva, and urine diminish with time, virus can be readily recovered from scabs throughout convalescence. Therefore, patients should be isolated and considered infectious until all scabs separate. For the past century, two distinct types of smallpox were recognized. Variola minor was distinguished by milder systemic toxicity and more diminutive pox lesions, and caused 1% mortality in unvaccinated victims. However, the prototypical disease variola major caused mortality of 3% and 30% in the vaccinated and unvaccinated, respectively. Other clinical forms associated with variola major, flat-type and hemorrhagic type smallpox were notable for severe mortality. A naturally occurring relative of variola, monkey pox, occurs in Africa, and is clinically indistinguishable from smallpox with the exception of a lower case fatality rate and notable enlargement of cervical and inguinal lymph nodes.

h. **Venezuelan Equine Encephalitis:** Incubation period 1–6 days. Acute systemic febrile illness with encephalitis developing in a small percentage (4% children; < 1% adults). Generalized malaise, spiking fevers, rigors, severe headache, photophobia, and myalgias for 24–72 hours. Nausea, vomiting, cough, sore throat, and diarrhea may follow. Full recovery from malaise and fatigue takes 1–2 weeks. The incidence of CNS disease and associated morbidity and mortality would be much higher after a BW attack. Susceptibility is high (90-100%), and nearly 100% of those infected develop overt illnesses. The overall case fatality rate for VEE is <1%, although it is somewhat higher in the very young or aged. Recovery from an infection results in excellent short-term and long-term immunity. VEE is primarily an acute, incapacitating, febrile illness with encephalitis developing in only a small percentage of the infected population. Most VEE infections are mild (EEE and

WEE are predominantly encephalitis infections). After an incubation period from 1–6 days, onset is usually sudden. The acute phase lasts 24–72 hours and is manifested by generalized malaise, chills, spiking high fevers (38C-40.5C), rigors, severe headache, photophobia, and myalgias in the legs and lumbosacral area. Nausea, vomiting, cough, sore throat, and diarrhea may follow. Physical signs include conjunctival injection, erythematous pharynx and muscle tenderness. Patients would be incapacitated by malaise and fatigue for 1–2 weeks before full recovery. During natural epidemics, approximately 4% of infected children (<15 years old) and less than 1% of adults will develop signs of severe CNS infection (35% fatality for children and 10% for adults). Adults rarely develop neurologic complications during natural infections. Experimental aerosol challenges in animals suggest that the incidence of CNS disease and associated morbidity and mortality would be much higher after a BW attack, as the VEE virus would infect the olfactory nerve and spread directly to the CNS. Mild CNS findings would include lethargy, somnolence, or mild confusion, with or without nuchal rigidity. Seizures, ataxia, paralysis, or coma follow more severe CNS involvement. VEE infection during pregnancy may cause encephalitis in the fetus, placental damage, abortion, or severe congenital neuroanatomical anomalies.

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

which features renal failure as an integral part of the disease process. Apart from epidemiologic and intelligence information, some distinctive clinical features may suggest a specific etiologic agent. While hepatic involvement is common among the VHFs, a clinical picture dominated by jaundice and other features of hepatitis is only seen in some cases of Rift Valley fever, Congo-Crimean, Marburg, and Ebola HFs, and yellow fever. Kyanasur Forest disease and Omsk hemorrhagic fever are notable for pulmonary involvement, and a biphasic illness with subsequent CNS manifestations. Among the arenavirus infections, Lassa fever can cause severe peripheral edema due to capillary leak, but hemorrhage is uncommon, while hemorrhage is commonly caused by the South American arenaviruses. Severe hemorrhage and nosocomial transmission are typical for Congo-Crimean HF. Retinitis is commonly seen in Rift Valley fever, and hearing loss is common among Lassa fever survivors. Because of their worldwide occurrence, additional consideration should be given to Hantavirus infections. Classic HFRS has a severe course that progresses sequentially from fever through hemorrhage, shock, renal failure, and polyuria. Nephropathia endemica features prominent fever, myalgia, abdominal pain, and oliguria, without shock or severe hemorrhagic manifestations. North American cases of Hantavirus Pulmonary Syndrome (HPS) due to the Sin Nombre virus lack hemorrhagic manifestations and renal failure, but nevertheless carry a very high mortality due to rapidly progressive and severe pulmonary capillary leak, which presents as ARDS. These syndromes may overlap. Subclinical or clinical pulmonary edema may occur in HFRS and nephropathia endemica, while HFRS has complicated HPS due to South American Hantaviruses and the Bayou and Black Creek Canal viruses in North America. Mortality may be substantial, ranging from 0.2% percent for nephropathia endemica, to 50 to 90 percent among Ebola victims.

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

little as 24 hours in cases of severe food borne botulism. The autonomic effects of botulism are manifested by typical anticholinergic signs and symptoms: dry mouth, ileus, constipation, and urinary retention. Nausea and vomiting may occur as nonspecific sequelae of an ileus. Dilated pupils (mydriasis) are seen in approximately 50 percent of cases. Sensory symptoms usually do not occur. Botulinum toxins do not cross the blood/brain barrier and do not cause CNS disease. However, the psychological sequelae of botulism may be severe and require specific intervention. Physical examination usually reveals an afebrile, alert, and oriented patient. Postural hypotension may be present. Mucous membranes may be dry and crusted and the patient may complain of dry mouth or sore throat. There may be difficulty with speaking and swallowing. Gag reflex may be absent. Pupils may be dilated and even fixed. Ptosis and extraocular muscle palsies may also be present. Variable degrees of skeletal muscle weakness may be observed depending on the degree of progression in an individual patient. Deep tendon reflexes may be present or absent. With severe respiratory muscle paralysis, the patient may become cyanotic or exhibit narcosis from CO_2 retention.

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

l. **Staphylococcal Enterotoxin B:** Latent period of 3–12 hours after aerosol exposure is followed by sudden onset of fever, chills, headache, myalgia, and nonproductive cough. Some patients may develop shortness of breath and retrosternal chest pain. Patients tend to plateau rapidly to a fairly stable clinical

state. Fever may last 2 to 5 days, and cough may persist for up to 4 weeks. Patients may also present with nausea, vomiting, and diarrhea if they swallow the toxin. Presumably, higher exposure can lead to septic shock and death. Symptoms of SEB intoxication begin after a latent period of 3–12 hours after inhalation, or 4–10 hours after ingestion. Symptoms include nonspecific flu-like symptoms (fever, chills, headache, myalgias), and specific features dependent on the route of exposure. Oral exposure results in predominantly gastrointestinal symptoms: nausea, vomiting, and diarrhea. Inhalation exposures produce predominantly respiratory symptoms: nonproductive cough, retrosternal chest pain, and dyspnea. GI symptoms may accompany respiratory exposure due to inadvertent swallowing of the toxin after normal mucocilliary clearance. Respiratory pathology is due to the activation of pro-inflammatory cytokine cascades in the lungs, leading to pulmonary capillary leak and pulmonary edema. Severe cases may result in acute pulmonary edema and respiratory failure. The fever may last up to five days and range from 103 to 106°F, with variable degrees of chills and prostration. The cough may persist up to four weeks, and patients may not be able to return to duty for two weeks. Physical examination in patients with SEB intoxication is often unremarkable. Conjunctival injection may be present, and postural hypotension may develop due to fluid losses. Chest examination is unremarkable except in the unusual case where pulmonary edema develops. The chest X-ray is also generally normal, but in severe cases increased interstitial markings, atelectasis, and possibly overt pulmonary edema or an ARDS picture may develop.

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

skin involvement with burning pain, redness and pruritus, rash or blisters, bleeding, and dyspnea. A late effect of systemic absorption is pancytopenia, predisposing to bleeding and sepsis.

BWP-FU FOLLOW-UP

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

STANDARDS:

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

BWP-I INFORMATION

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

STANDARDS:

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

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

c. **Glanders and Melioidosis:** The causative agents of Glanders and Melioidosis are Burkholderia mallei and Burkholderia pseudomallei, respectively. Both are gram-negative bacilli with a "safety-pin" appearance on microscopic examination. Both pathogens affect domestic and wild animals, which, like humans, acquire the diseases from inhalation or contaminated injuries. B. mallei is primarily noted for producing disease in horses, mules, and donkeys. In the past man has seldom been infected, despite frequent and often close contact with infected animals. This may be the result of exposure to low concentrations of organisms from infected sites in ill animals and because strains virulent for equids are often less virulent for man. There are four basic forms of disease in horses and man. The acute forms are more common in mules and donkeys, with death typically occurring 3 to 4 weeks after illness onset. The chronic form of the disease is more common in horses and causes generalized lymphadenopathy, multiple skin nodules that ulcerate and drain, and induration, enlargement, and nodularity of regional lymphatics on the extremities and in other areas. The lymphatic thickening and induration has been called farcy. Human cases have occurred primarily in veterinarians, horse and donkey caretakers, and abattoir workers. B. pseudomallei is widely distributed in many tropical and subtropical regions. The disease is endemic in Southeast Asia and northern Australia. In northeastern Thailand, B. pseudomallei, is one of the most common causative agents of community-acquired septicemia. Melioidosis presents in humans in several distinct forms, ranging from a subclinical illness to an overwhelming septicemia, with a 90% mortality rate and death within 24–48 hours after onset. Also, melioidosis can reactivate years after primary infection and result in chronic and life-threatening disease. These organisms spread to man by invading the nasal, oral, and conjunctival mucous membranes, by inhalation into the lungs, and by invading abraded or lacerated skin. Aerosols from cultures have been observed to be highly infectious to laboratory workers. Biosafety level 3 containment practices are required when working with these organisms in the laboratory. Since aerosol spread is efficient, and there is no available vaccine or reliable therapy, B. mallei and B. pseudomallei have both been viewed as potential BW agents.

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

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

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

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

respiratory isolation should be applied to secondary contacts for 17 days post-exposure. Vaccinia vaccination and vaccinia immune globulin each possess some efficacy in post-exposure prophylaxis.

h. **Venezuelan Equine Encephalitis:** The Venezuelan equine encephalitis (VEE) virus complex is a group of eight mosquito-borne alphaviruses that are endemic in northern South America and Trinidad and causes rare cases of human encephalitis in Central America, Mexico, and Florida. These viruses can cause severe diseases in humans and Equidae (horses, mules, burros, and donkeys). Natural infections are acquired by the bites of a wide variety of mosquitoes. Equidae serve as amplifying hosts and source of mosquito infection. Western and Eastern Equine Encephalitis viruses are similar to the VEE complex, are often difficult to distinguish clinically, and share similar aspects of transmission and epidemiology. The human infective dose for VEE is considered to be 10-100 organisms, which is one of the principal reasons that VEE is considered a militarily effective BW agent. Neither the population density of infected mosquitoes nor the aerosol concentration of virus particles has to be great to allow significant transmission of VEE in a BW attack. There is no evidence of direct human-to-human or horse-to-human transmission. Natural aerosol transmission is not known to occur. VEE particles are not considered stable in the environment, and are thus not as persistent as the bacteria responsible for Q fever, tularemia or anthrax. Heat and standard disinfectants can easily kill the VEE virus complex.

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

j. **Botulinum:** The botulinum toxins are a group of seven related neurotoxins produced by the spore-forming bacillus Clostridium botulinum and two other Clostridia species. These toxins, types A through G, are the most potent neurotoxins known; paradoxically, they have been used therapeutically to treat spastic conditions (strabismus, blepharospasm, torticollis, tetanus) and cosmetically to treat wrinkles. The spores are ubiquitous; they germinate into vegetative bacteria that produce toxins during anaerobic incubation. Industrial-scale fermentation can produce large quantities of toxin for use as a BW agent. There are three epidemiologic forms of naturally occurring botulism: food borne, infantile, and wound. Botulinum could be delivered by aerosol or used

to contaminate food or water supplies. When inhaled, these toxins produce a clinical picture very similar to food borne intoxication, although the time to onset of paralytic symptoms after inhalation may actually be longer than for food borne cases, and may vary by type and dose of toxin. The clinical syndrome produced by these toxins is known as "botulism."

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

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

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

BWP-L LITERATURE

OUTCOME: The patient/family will receive literature about exposure to biological weapons.

STANDARDS:

1. Provide the patient/family with literature on biological weapons.
2. Discuss the content of the literature.

BWP-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

BWP-M MEDICATIONS

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

STANDARDS:

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

BWP-P PREVENTION

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

STANDARDS:

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

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

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

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

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

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

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

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

BWP-SM STRESS MANAGEMENT

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

STANDARDS:

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

BWP-TE TESTS

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

STANDARDS:

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

BWP-TX TREATMENT

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

STANDARDS:

1. Explain that the treatment plan will be made by patient and the healthcare team after reviewing available options
    a. **Anthrax:** Although effectiveness may be limited after symptoms are present, high dose antibiotic treatment should be undertaken. Supportive therapy may be necessary.
    b. **Brucellosis:** Antibiotic therapy in combination with other medications for six weeks is usually sufficient in most cases. More prolonged regimens may be required for patients with complications of meningoencephalitis, endocarditis, or osteomyelitis.
    c. **Glanders and Melioidosis:** Therapy will vary with the type and severity of the clinical presentation. Patients with localized disease, may be managed with oral antibiotics for a duration of 60–150 days. More severe illness may require parenteral therapy and more prolonged treatment.
    d. **Plague:** Early administration of antibiotics is critical, as pneumonic plague is invariably fatal if antibiotic therapy is delayed more than one day after the onset of symptoms.
    e. **Q-Fever:** Q fever is generally a self-limited illness even without treatment, but antibiotic therapy should be provided to prevent complications of the disease. Q fever endocarditis (rare) is much more difficult to treat.
    f. **Tularemia:** Administration of antibiotics with early treatment is very effective.

g. **Smallpox:** At present there is no effective chemotherapy, and treatment of a clinical case remains supportive.

h. **Venezuelan Equine Encephalitis:** Treatment is supportive only. Treat uncomplicated VEE infections with analgesics to relieve headache and myalgia. Patients who develop encephalitis may require anticonvulsants and intensive supportive care to maintain fluid and electrolyte balance, ensure adequate ventilation, and avoid complicating secondary bacterial infections.

i. **Viral Hemorrhagic Fevers:** Intensive supportive care may be required. Antiviral therapy with ribavirin may be useful in several of these infections (available only as IND under protocol). Convalescent plasma may be effective in Argentine hemorrhagic fever (available only as IND under protocol).

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

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

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

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

BL - Blood Transfusions

BL-C COMPLICATIONS

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

STANDARDS:

1. Explain that there are two potential major complications from blood transfusions that occasionally occur.
2. Explain that the patient may develop volume overload as a result of the blood transfusion, particularly if the patient is a neonate, elderly, or has cardiopulmonary disease. The symptoms which should be reported to the nurse immediately may include:
    a. Restlessness
    b. Headache
    c. Shortness of breath
    d. Wheezing
    e. Cough
    f. Cyanosis
3. Explain that a transfusion reaction may occur. Explain that transfusion reactions may be severe and can include anaphylaxis or death. Instruct the patient/family that the following symptoms should be reported to the nurse immediately. Discuss that the symptoms are usually mild and may include:
    a. Hives
    b. Itching
    c. Rashes
    d. Fever
    e. Chills
    f. Muscle aches
    g. Back pain
    h. Chest pain
    i. Headaches
    j. Warmth in the vein

4. Explain that blood supplies are currently thoroughly tested for blood borne diseases such as HIV or hepatitis. There still remains a small risk of transmission of blood borne disease from transfusion of blood or blood components.

BL-EQ EQUIPMENT

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

STANDARDS:

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

BL-FU FOLLOW-UP

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

STANDARDS:

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

BL-L LITERATURE

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

STANDARDS:

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

BL-S SAFETY

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

STANDARDS:

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

BL-TE TESTS

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

STANDARDS:

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

BL-TX TREATMENT

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

STANDARDS:

1. Explain that a blood transfusion is the transference of blood from one person to another.

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

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 (e.g., increased IQ, improved bonding, easier to digest).
3. Identify risk reducing benefits to the baby (e.g., 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 (e.g., assure correct latch-on, apply cool moist tea bags). **Refer to "BF-ON Latch-On" on page 141**.

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 (e.g., 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 (e.g., 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. Emphasizing 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 four 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, e.g., milk stays good in the refrigerator for 24 hours, in the refrigerator freezer for 1 month, and in the 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

OUTCOME: 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, e.g., low intensity cry, small body movements, smacking, rooting.
2. Explain late hunger cues, e.g., 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 LITERATURE

OUTCOME: The patient/family will receive literature about breastfeeding.

STANDARDS:

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

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 (e.g., 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 (e.g., 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 healthcare 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-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.

b. Identification of the patient's nutritional problem.
c. Identification of a specific nutrition intervention therapy plan.
d. Evaluation of the patient's nutritional care outcomes.
e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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 (e.g., chocolate, gas forming food, and highly seasoned foods).
3. Emphasize the increased need for water in the diet of breastfeeding mothers.

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-ON LATCH-ON

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

STANDARDS:

1. Identify the cues that indicate readiness to feed, e.g., 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 (e.g., 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 four 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, e.g., 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 the mother feels the baby has 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. Who will give you cues to readiness when they open their mouths when they see something coming
    c. Who will close lips over a spoon
    d. Who will keep food in their mouth instead of spitting it out
    e. Who 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

OUTCOME: 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 (e.g., 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 that 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. Practicing self-hypnosis
    k. Using positive imagery
    l. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. Participating in 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, e.g., 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 (e.g., closely observing the baby while nursing to interrupt potential biting).
3. Explain the variety of techniques to discourage persistent biting (e.g., 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 (e.g., 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, e.g., 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 (e.g., cellulitis) or generalized infection, e.g., 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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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 (e.g., 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 - Sun Exposure" on page 813**.

BURN-L LITERATURE

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

STANDARDS:

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

BURN-M MEDICATIONS

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

STANDARDS:

1. Discuss the role of medication in the patient's treatment plan.
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 and symptoms that should prompt a return visit.
4. Discuss importance of full participation with the medication plan.
5. Emphasize the importance of follow-up.

BURN-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.

4. Assist the patient/family in developing an appropriate nutrition care plan.

BURN-N NUTRITION

OUTCOME: The patient/family will understand the role of adequate nutrition for the healing of burns.

STANDARDS:

1. Explain the importance of adequate nutrition and hydration in the repair of tissue.
2. Refer to a registered dietician as appropriate.

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:
        i. Install smoke detectors
        ii. Don't smoke in bed
        iii. Practice home fire drills and "stop, drop, and roll"
        iv. Don't let children play with matches, lighters, flames, or fireworks
        v. Explain that fireworks are extremely dangerous
        vi. Ensure heat lamps and other sources of heat have timers or appropriate safety devices
        vii. Never leave burning candles unattended
        viii. Assure that electrical wiring, outlets, and electrical devices are safe
    b. To prevent chemical burns:
        i. Child-proof cabinets and store chemicals out of the reach of children
        ii. Use caution in storing cleaning materials
        iii. Wear gloves and other protective clothing when using chemicals
    c. To prevent heat/steam burns:
        i. Set your water heater no higher than 120°F.

ii. Test the water temperature before entering or putting children into bathtubs/showers.

iii. Use cool water humidifiers not steam vaporizers.

iv. 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.

v. 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.

vi. Use extreme caution when lifting lids from pots because steam may suddenly be released.

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

d. To prevent electrical burns:

i. Put covers on any electrical outlets not currently in use.

ii. Don't use items with frayed or damaged electrical cords.

iii. Don't overload outlets.

iv. Keep electrical devices away from water and use ground fault circuit interrupter outlets near water sources.

v. Don't modify electrical cords or plugs.

vi. Use power surge protectors.

4. Review the dangers inherent in the use of wood-burning stoves, "charcoal pans," kerosene heaters, and other open flames.
5. Encourage the use and proper maintenance of smoke detectors, carbon monoxide detectors, and fire suppression systems.
6. Encourage routine practices of fire escape plans, chimney cleaning, and fireworks safety.
7. Review the safe use of electricity and natural gas.
8. 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 because butter may contain salt which can worsen the burn.
   b. Don't use ice, because 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 - Pain Management" on page 657.**

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, e.g., 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, e.g., increasing redness, purulent discharge, fever, increasing pain, or swelling.
4. Detail the supplies necessary for care of this burn (if any) and how/where they might be obtained and proper methods for disposal of used supplies.
5. As appropriate, have the patient/family demonstrate burn care techniques.
6. Emphasize the importance of follow-up.

C

CA - Cancer

CA-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family/caregiver will understand the process of developing an advance directive and its role in maintaining a sense of control in the patient's medical care and decisions.

STANDARDS:

1. Explain that patients may lose the ability to make their own decisions and an advance directive will be able to express the patient's desires prior to the loss of decision-making abilities.
2. Review the option of Advanced Directives/Living Will with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
3. Refer to appropriate services to assist the patient in making a living will, e.g., Social Services, Clergy, Lawyer.
4. **Refer to "ADV - Advance Directives" on page 40.**

CA-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand the normal function of the organ(s)/ site(s) being affected by the cancer.

STANDARD:

1. Explain the relationship between the anatomy and physiology of the system involved and the cancer.
2. Discuss the changes caused by the cancer and the potential impact on health and well being.

CA-C COMPLICATIONS

OUTCOME: The patient/family/caregiver will understand the complications associated with cancer and cancer therapy and that these may or may not be treatable.

STANDARDS:

1. Discuss the complications of the cancer and its treatment pertaining to this patient.
2. Explain that many therapies for cancer depress the immune system and that infection is a major risk.

3. Discuss that nausea and vomiting are frequent side effects of many cancer therapies and that these can often be successfully medically managed.
4. Discuss that pain may be a complication of the disease process or the therapy. **Refer to "PM - Pain Management" on page 657.**

CA-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving optimal physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

CA-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

1. Explain that the outcome of the disease processes may be influenced by choices related to health and lifestyles, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges, may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.

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

CA-DP DISEASE PROCESS

OUTCOME: The patient/family/caregiver will understand the specific cancer and its disease process.

STANDARD:

1. Explain the specific type/site and causative/risk factors of the cancer and staging of the tumor, as appropriate.
2. Discuss signs and symptoms and the usual progression of the specific cancer.
3. Discuss the prognosis of the specific cancer.

CA-EQ EQUIPMENT

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

STANDARDS:

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

CA-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

CA-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of cancer and develop a plan for comprehensive care.

STANDARDS:

1. Explain the home management techniques necessary based on the status of the patient. Explain that these home management techniques may change frequently.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

CA-L LITERATURE

OUTCOME: The patient/family/caregiver will receive literature regarding cancer.

STANDARDS:

1. Provide parent/family with literature on cancer.
2. Review the content of the literature.

CA-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

1. Discuss lifestyle adaptations that may be required, such as diet, physical activity, sexual activity, role changes, communication skills and interpersonal relationships.
2. Discuss that family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Review community resources available to assist the patient in making changes. Refer as appropriate.

CA-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.

2. Discuss the risks, benefits and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

CA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for the treatment or management of cancer.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CA-N NUTRITION

OUTCOME: The patient/family/caregiver will understand the nutritional care in cancer.

STANDARDS:

1. Explain that small frequent meals or modified textures can decrease nausea and vomiting, or other complications associated with the therapy or the disease process.
2. Discuss the use of oral supplements or nutrient dense snacks to boost caloric needs as appropriate.
3. Encourage adequate fluid for hydration.

4. Explain that medications may be provided to enhance appetite, decrease adverse effects of therapy, or the disease process to assist in maintenance of proper nutrition.
5. Discuss caloric needs to improve or maintain nutritional status and provide appropriate micronutrients. Refer to registered dietitian for MNT.
6. Discuss the patient's right to decline nutritional support.

CA-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of developing cancer.

STANDARDS:

1. Discuss ways to reduce the risk of cancer:
   a. Tobacco cessation (**Refer to "TO-QT Quit" on page 832**)
   b. Use of sunscreens and/or reduction of sun exposure
   c. Reduce exposure to chemicals
   d. Protected sex (condoms, abstinence, or monogamy)
   e. Other preventive strategies as currently determined by the American Cancer Society
2. Discuss the importance of health surveillance, recommended screening and routine health maintenance for a patient of this age/sex, e.g., PAP smears, colonoscopy, BSE, TSE, PSA.
3. Emphasize the importance of the early cancer detection. Encourage the patient to come in early if signs of cancer (e.g., unexpected weight loss, fatigue, GI bleeding, new lumps or bumps, nagging cough or hoarseness, change in bowel or bladder habits, changes in warts or moles, sores that don't heal) are detected.

CA-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that pain management is specific to the disease process and the patient; and may be multifaceted. **Refer to "PM - Pain Management" on page 657.**
2. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain or nausea and vomiting.
3. Explain non-pharmacologic measures that may be helpful with pain control.

CA-REF REFERRAL

OUTCOME: The patient/family will understand the referral and contract health services process.

STANDARDS:

1. Emphasize that referrals to outside providers by Indian Health Service primary providers typically will be processed by Contract Health Services.
2. Explain the procedure for the referral to the private sector is usually based on a priority system and/or waiting list.
3. Explain that coverage by insurance companies and Medicare/Medicaid packages will be utilized prior to contract health service funds, in most cases. The Indian Health Service is a payer of last resort.
4. Discuss the rules/regulations of Contract Health Services.
5. Refer, as appropriate, to community resources for Medicaid/Medicare enrollment, e.g., benefits coordinator, social services. **Refer to "ADV - Advance Directives" on page 40.**
6. Discuss the importance of follow-up care and the requirement to notify contract health services of any future appointments and procedures by the private sector. **Referrals are for one visit only**, unless otherwise specified. Future and/or additional referrals must be approved prior to the appointment.

CA-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress can result in a worsened prognosis in cancer patients.
2. Explain that effective stress management may help reduce the morbidity and mortality associated with cancer, as well as, help improve the patient's sense of health and well-being.
3. Discuss various stress management strategies such as maintaining a healthy lifestyle. Some examples may include:
   a. Becoming aware of your own reactions to stress
   b. Recognizing and accepting your limits
   c. Talking with people you trust about your worries or problems
   d. Setting realistic goals
   e. Getting enough sleep

f. Maintaining a healthy diet

g. Exercising regularly

h. Taking vacations

i. Practicing meditation, self-hypnosis, and positive imagery

j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation

k. Participating in spiritual or cultural activities

4. Provide referrals as appropriate.

CA-TE TESTS

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

STANDARDS:

1. Explain that tests may be necessary for diagnosis or staging of cancer and follow-up therapy. Discuss the procedure for the test to be performed, the benefits expected, and any associated risks.
2. Explain the alternatives to the proposed test(s) and the risk(s) and benefits(s) of the alternatives, including the risk of non-testing.
3. Explain any necessary preparation for testing, e.g., NPO status, bowel preps.
4. Explain the meaning of the test results, as appropriate.

CA-TX TREATMENT

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

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and adherence to the treatment plan.
2. Explain the difference between palliative and curative treatments. Explain that treatments may prolong the patient's life and improve the quality of life by increasing patient comfort or curing the disease process.
3. Discuss therapies that may be utilized, including chemotherapy, surgical debulking or removal of tumor, and radiation therapy as appropriate.
4. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
5. Discuss the importance of maintaining a positive mental attitude.

CVA - Cerebrovascular Disease

CVA-C COMPLICATIONS

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

STANDARDS:

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

CVA-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

CVA-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, e.g., diet, exercise, sleep, stress management, hygiene, full participation in the medical plan.
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 healthcare provider to determine if there are interactions with prescribed treatment.

4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges, may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

CVA-DP DISEASE PROCESS

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

STANDARDS:

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

CVA-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss the types and the features of the assisted medical devices/equipment as appropriate.
3. Discuss and/or demonstrate the proper use, care, and cleaning of assisted medical devices/equipment.
4. Explain that the patient/family/caregiver will demonstrate the proper use of the assisted medical devices/equipment.
5. Discuss the signs of assisted medical devices/equipment malfunction and the proper action in case of malfunction as appropriate.

CVA-FU FOLLOW-UP

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

STANDARDS:

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

CVA-HM HOME MANAGEMENT

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

STANDARDS:

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

CVA-L LITERATURE

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

STANDARDS:

1. Provide patient/family with literature on the cerebrovascular disease.
2. Discuss the content of the literature.

CVA-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

CVA-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

CVA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of cerebrovascular disease.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CVA-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition in cerebrovascular disease.

STANDARDS:

1. Discuss the relationship between diet and cerebrovascular disease, hypertension, elevated cholesterol, and obesity.
2. Explain the necessity of an appropriate diet plan and physical activity to achieve optimal weight and improve or correct lipids. Refer to registered dietitian for MNT.
3. Discuss ways to prevent future strokes: linolenic acid from walnuts, canola, and soybean oils may be protective. Increased fruit and vegetable intake is also protective.
4. Explain that small bites of food, and slow, adequate chewing as appropriate.
5. Explain that six to eight cups of fluids are needed daily.

CVA-P PREVENTION

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

STANDARDS:

1. Discuss that prevention of cerebrovascular disease is far better than controlling the disease after it has developed.

2. Explain that consuming a diet low in fat, and controlling weight, lipid levels and blood pressure will help to prevent CVA.
3. Discuss that persons with uncontrolled diabetes and uncontrolled hypertension and uncontrolled dyslipidemia are more likely to develop CVA. Stress the importance of controlling these disease processes. **Refer to "DM - Diabetes Mellitus" on page 318, "HTN - Hypertension" on page 524, "LIP - Hyperlipidemia/ Dyslipidemias" on page 517, "OBS - Obesity" on page 621.**

CVA-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

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

CVA-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress can contribute to increases in blood pressure, which increases the patient's risk for stroke.
2. Explain that uncontrolled stress can interfere with the treatment of cerebrovascular disease.
3. Explain that effective stress management may help prevent progression of cerebrovascular disease, as well as help improve the patient's health and well-being.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality from cerebrovascular disease.

5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
   a. Becoming aware of your own reactions to stress
   b. Recognizing and accepting your limits
   c. Talking with people you trust about your worries or problems
   d. Setting realistic goals
   e. Getting enough sleep
   f. Maintaining a healthy diet
   g. Exercising regularly
   h. Taking vacations
   i. Practicing meditation, self-hypnosis, and positive imagery
   j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   k. Participating in spiritual or cultural activities
6. Provide referrals as appropriate.

CVA-TE TESTS

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

STANDARDS:

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

CVA-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options and will participate in the design of the treatment plan, goals, and expected results.

STANDARDS:

1. List the possible procedures that might be utilized to treat the arterial blockage, e.g., angioplasty, carotid endarterectomy.

2. Briefly explain each of the possible treatments.
3. Explain that the treatment decision will be made by the patient and medical team after reviewing the results of diagnostic tests.
4. Discuss the importance of fully participating in the treatment plan and scheduled follow-up, including physical therapy.

CWP - Chemical Weapons

CWP-C COMPLICATIONS

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

STANDARDS:

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

CWP-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

CWP-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, e.g., diet, exercise, sleep, stress management, hygiene, full participation in the medical plan.
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 healthcare provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.

5. Discuss that traditions, such as sweat lodges, may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

CWP-DP DISEASE PROCESS

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

STANDARDS:

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

   a. **NERVE AGENTS**

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

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

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

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

   iv. **VX:** Symptoms can be expected from 4 to 14 hours following exposure to VX. Of all the nerve agents, VX is the most volatile and can be easily

transformed into gas. It is also the most toxic and more likely to produce the lethal side effects following exposure.

b. **BLISTER/VESICANT AGENTS**

The most likely routes of exposure to blister/vesicant agents are inhalation, dermal contact, and ocular contact. The severity of symptoms will be dependant upon the amount and route of exposure, as well as the pre-morbid condition of the victim.

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

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

iii. **Nitrogen Mustards:** These can be found in a variety of forms; oily liquids, vapor, or solid, and with a variety of different smells. The symptoms of Nitrogen exposure usually do not occur immediately, and can take up to several hours to manifest themselves. Skin can become reddened within a few hours, and could be followed by blistering within 6 to 12 hours. The eyes may become irritated, painful, swollen, and tearful,

with high amounts of exposure causing blindness. Nose and sinus pain, coughing, sore throat, and shortness of breath may occur within hours. Abdominal pain, nausea, vomiting, diarrhea. Under extreme circumstances, individuals could experience tremors, in coordination, and seizures. The liquid form is more likely to produce second or third degree burns that are more likely to leave scarring later. Excess inhalation of the vapors can cause long-term respiratory disorders, and excess exposure to the eyes can cause chronic eye problems. Exposure has been associated with bone marrow suppression beginning as early as 3 to 5 days following the exposure, which can lead to anemia, bleeding, and increased risk for infection. Prolonged exposure to nitrogen mustards has been linked top leukemia.

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

c. **BLOOD AGENTS**

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

Chronically exposed workers may complain of headache, eye irritation, easy fatigue, chest discomfort, palpitations, loss of appetite, and nosebleeds.

d. **PULMONARY AGENTS**

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

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

have an increased risk of diseases and death associated with long term lung disorders.

CWP-FU FOLLOW-UP

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

STANDARDS:

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

CWP-I INFORMATION

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

STANDARDS:

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

arsenic, and thus has some effects similar to arsenic poisoning, including stomach ailments and low blood pressure.

f. **Sulfur Mustard:** This can be clear or a yellow-brown colored in its oily liquid or solid state. It can also vaporize and spread through the environment. SM sometimes smells like garlic, mustard, onions, or nothing at all. It can last in the environment for up to 2 days following release in regular weather conditions, but under very cold conditions, it can last for up to weeks or months.

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

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

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

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

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

stronger, more unpleasant smell. Phosgene is non-flammable, unless mixed with certain other chemicals.

CWP-L LITERATURE

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

STANDARDS:

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

CWP-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

CWP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
    a. Assessment of the nutrition related condition.
    b. Identification of the patient's nutritional problem.
    c. Identification of a specific nutrition intervention therapy plan.
    d. Evaluation of the patient's nutritional care outcomes.

e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CWP-P PREVENTION

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

STANDARDS:

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

d. **Pulmonary Agents**:

i. No current antidotes are available. Supportive therapy must be initiated.

CWP-TE TESTS

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

STANDARDS:

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

CWP-TX TREATMENT

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

STANDARDS:

1. Explain that the treatment plan will be made by the patient and the healthcare team after reviewing available options.
2. **Nerve Agents:** Atropine should be continued at 5–10 minute intervals, until the adequate resolution of symptoms (Secretions have diminished and breathing is comfortable). Continue Diazepam if required for the prevention of convulsions.

Phentolamine (5mg IV for adults, 1mg IV for children) can be used for 2-PAM induced hypertension.

3. **Blister Agents/Vesicants:**
    a. Mustard Blisters: Apply a one-eighth of an inch thick layer of mafenide acetate or silver sulfadiazine cream to be used as a topical anti-bacterial. If the blister worsens to an infected state, appropriate antibiotic therapy should be sought.
    b. Inhalation of Mustards: In cases of severe RT injury, where a pt is infected with a pneumonal infection, aggressive antibiotic therapy is required
    c. Mustard ingestion: In treating systemic symptoms 0.4-0.8 mg SQ Atropine may be useful in reducing GI activity. If the victims' white blood cell count were significantly reduced, isolation and appropriate antibiotic therapy would be needed.
4. **Blood Agents:** See above for post-exposure prophylaxis**.**
5. Pulmonary Agents:
    a. Antimicrobial treatment is reserved only for cases of acquired bacterial bronchitis/pneumonitis.
    b. At sufficiently high doses of these agents, pulmonary edema is more than likely to follow. In these cases, large doses of steroids must be administered as soon as possible, preferably started within 15 minutes of exposure.
    c. Dexamethasone Na Phosphate: 4 puffs must be inhaled at the earliest possible time, then 1 puff q 3 mins until irritation has subsided. After this, 5 puffs q 15 minutes to total 150 puffs. Following this, 1 puff q 1h daily, with 5 puffs q 15mins to total 30 puffs in preparation for nighttime sleep. This regimen should be continued for at least 5 days.
    d. For treating life threatening situations, the above inhaled regimen should be supplemented with the following:
        i. Day 1: 1000 mg IV prednisolone
        ii. Day 2: 3800 mg IV prednisolone
        iii. Day 3: 5700 mg IV prednisolone
        iv. Beginning day 6, systemic CS dose should be reduced, provided the CXR remains clear
    e. If the patient is pre-disposed to pulmonary infection complications, adjuvant antibiotic coverage should also be considered.

CP - Chest Pain

CP-DP DISEASE PROCESS

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

STANDARDS:

1. Discuss various etiologies for chest pain, e.g., cardiovascular, pulmonary, musculoskeletal, gastrointestinal.
2. Explain that it is often very difficult to determine the cause of chest pain and 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 in the treatment of chest pain.

STANDARDS:

1. Discuss the importance of follow-up care, including the importance of assessing the effectiveness of treatment and correcting problems that may develop.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.

5. Discuss the availability of community resources and support services and refer as appropriate.

CP-L LITERATURE

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

STANDARDS:

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

CP-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

CP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of chest pain.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CP-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition in the maintenance of wellness.

STANDARDS:

1. Discuss as appropriate that some foods might exacerbate chest pain.
2. Explain that small frequent feedings are beneficial.
3. Restrict saturated fats, dietary cholesterol, and sodium as necessary. Increase fiber as tolerated; include an adequate fluid intake.
4. Refer to a registered dietician for MNT as appropriate.

CP-SM STRESS MANAGEMENT

OUTCOME: 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 - Coronary Artery Disease" on page 269, "GAD - Generalized Anxiety Disorder" on page 437.**
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 healthy diet

g. Exercising regularly

h. Taking vacations

i. Practicing meditation, self-hypnosis, and positive imagery

j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation

k. Participating in 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 the specific test ordered and collection method.
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 and instructions for the test, e.g., NPO status.

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

CHN-CAR CAR SEATS AND AUTOMOBILE SAFETY

OUTCOME: The patient/family will understand measures that will improve car safety.

STANDARDS:

1. 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.
2. Discuss the requirement of a NTSB approved car seat. Not all infant carriers are approved for use in automobiles.
3. Explain the dangers posed by things that might divert attention from driving, such as smoking, cell phone use, eating, CDs and radios, etc.
4. Emphasize the importance of never driving while under the influence of alcohol, sedatives, and/or street drugs.
5. Emphasize not to leave infant/children unattended in a vehicle (motor running, not running, keys in car) due to potential incidents; e.g., vehicle gears shifted and car goes in motion, electric windows cause injury to child, keys locked in vehicle with child, heat/cold exposure, abduction or child wandering away.

CHN-ECC EARLY CHILD CARIES

OUTCOME: The patient/family will understand the importance of good oral hygiene and prevention of early childhood caries.

STANDARDS:

1. Discuss prevention of tooth decay (early childhood caries) by proper use of bottles, e.g., no bottles in bed, no propping of bottles, weaning by 12 months of age, nothing in the bottle except formula, breastmilk, or electrolyte solution.
2. Review oral hygiene habits. Discuss that the whole family should practice good oral hygiene. Explain methods of newborn oral hygiene, i.e. use of a soft washcloth to clean the gums.

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, to screen for disease, and to 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, crying patterns, hiccoughs, spitting up, thumb sucking.

CHN-I INFORMATION

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

STANDARDS:

1. Discuss that hand-washing is the best way to prevent the spread of infections to the newborn.
2. Stress the dangers of fever (>101 degrees Fahrenheit) in the newborn period and the importance of seeking immediate medical care. **Refer to "NF - Neonatal Fever" on page 608.**
3. Discuss that rectal temperature is a reliable method of temperature measurement in newborns.
4. 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).

5. Discuss the option of circumcision and care of the circumcised and uncircumcised penis in boys. Discuss the normal vaginal discharge or bleeding that baby girls may have.
6. Discuss newborn hygiene, e.g., bathing, cord care, avoidance of powders, skin and nail care, appropriate clothing for the season and environment.
7. Discuss signs/symptoms of illness and when to seek medical care, e.g., fever>100.4°F, seizure, certain rashes, irritability, lethargy, failure to eat, vomiting, diarrhea, jaundice, dehydration, apnea, cyanosis. **Refer to** **"NF - Neonatal Fever" on page 608**.
8. Discuss the immunization schedule and when the infant should receive the first immunization. **Refer to** **"IM - Immunizations" on page 547**.
9. Discourage use of medications in the newborn period.

CHN-L LITERATURE

OUTCOME: The parent/family will receive literature about child health issues.

STANDARDS:

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

CHN-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.

4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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 - Breastfeeding" on page 135**.
2. Emphasize that nothing should be given from the bottle but formula, breastmilk, water, or electrolyte solutions, e.g., no caffeinated beverages or other soft drinks.
3. Review formula preparation and storage of formula and/or breastmilk as appropriate. Discuss proper feeding technique for bottle and breastfeeding, i.e. feeding positions, latching on, demand feeding.
4. Review proper technique and position for bottle feeding, e.g., no propping of bottles, feed in semi-sitting position, no warming of bottles in the microwave.
5. Discuss the reasons for burping infants and methods of burping infants.
6. Discuss that infants have a need to suckle beyond what is necessary for nutrition. Discuss thumb sucking and pacifier use.
7. Discuss that solids are not needed until 4–6 months of age. Discourage the use of cereals added to formula except when specifically recommended by the healthcare provider.

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 that 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-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 and the importance of learning baby temperament: cuddle, rock, trying to console baby – crying usually peaks at 6 weeks. Encourage the parents to sleep when the infant sleeps.
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. Discuss the signs of depression and encourage parents to seek help if depression is suspected.

6. Discuss sibling rivalry and some techniques to help older siblings feel important. Encourage active participation of the father in caring for the infant and older siblings.
7. Review the community resources (financial, medical, WIC) available for help in coping with a new baby.
8. Encourage the mother to keep her postpartum checkup.

CHN-S SAFETY AND INJURY PREVENTION

OUTCOME: The parent/family will understand principles of injury prevention and will 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. The car seat should NEVER be in the front seat due to possible injury should the airbag deploy. Discuss the requirement of a NTSB approved car seat. Not all infant carriers are approved for use in automobiles.
3. Discuss the dangers posed by—direct sunlight, open flames, closed-up cars, siblings, plastic bags, tossing the baby in the air, second-hand cigarette smoke and shaken-baby syndrome. Discuss crib safety (slats less than 2 3/8 inches apart.)
4. Illustrate the proper way to support a newborn's head and back.
5. Explain that SIDS is decreased by back or side-lying and by not smoking in the home or car. Emphasize the importance of keeping home and car smoke-free. Discuss that soft bedding or toys and keeping the infant too warm may increase the risk of SIDS.
6. Stress the importance of carefully selecting child-care settings to assure child safety.
7. Discuss the importance of keeping a hand on the infant when the infant is lying on any surface over floor level to avoid falls.
8. Discuss the dangers posed by hot liquids, too hot bath water, microwaving baby bottles, and cigarettes or open flames. (Current recommendation is to set water heater to <120°F.)

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 months 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, e.g., 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 babies 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. Who will give you cues to readiness when they open their mouths when they see something coming
c. Who will close lips over a spoon
d. Who will keep food in their mouth instead of spitting it out
e. Who 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/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-CAR CAR SEATS AND AUTOMOBILE SAFETY

OUTCOME: The patient/family will understand measures that will improve car safety.

STANDARDS:

1. Stress the use of a properly secured, rear facing car seat EVERY TIME the infant rides in a vehicle. The car seat should be in the middle of the back seat of the vehicle.
2. Discuss the requirement of a NTSB approved car seat. Not all infant carriers are approved for use in automobiles.
3. Explain that the car seat should fit the child properly.
4. Explain the dangers posed by things that might divert attention from driving, such as smoking, cell phone use, eating, CDs and radios, etc.
5. Emphasize the importance of never driving while under the influence of alcohol, sedatives, and/or street drugs.
6. Emphasize not to leave infant/children unattended in a vehicle (motor running, not running, keys in car) due to potential incidents; e.g., vehicle gears shifted and car goes in motion, electric windows cause injury to child, keys locked in vehicle with child, heat/cold exposure, abduction or child wandering away.

CHI-ECC EARLY CHILD CARIES

OUTCOME: The patient/family will understand of good oral hygiene and prevention of early childhood caries.

STANDARDS:

1. Discuss prevention of tooth decay (early childhood caries) by proper use of bottles, e.g., no bottles in bed, no propping of bottles, weaning by 12 months of age, nothing in the bottle except formula, breastmilk or electrolyte solution.
2. Review oral hygiene habits. Discuss that the whole family should practice good oral hygiene. Explain methods of infant oral hygiene, e.g., use of a soft washcloth, soft tooth brush, or infant tooth cleaner to clean the gums/teeth.
3. Discuss, as appropriate, fluoride supplementation and that only non-fluoridated toothpaste should be used for infant tooth care.

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. Discuss language development.
6. Review adaptive behaviors:
    a. Smiles by 8 weeks.
    b. Shows 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.
7. Discuss signs of teething, ages at which teething usually occurs, and the relief for teething pain.
8. Discuss that toilet training should be delayed. Explain that curiosity about genitals is normal and to be expected.

9. Discuss sleep habits and transition objects for sleep.

CHI-HY HYGIENE

OUTCOME: The parent(s) will understand infant hygiene issues.

STANDARDS:

1. Discuss that washing hands often will reduce passing germs to the infant.
2. Bowel habits:
   a. Review constipation. Strongly discourage the use of enemas or homemade preparations to relieve constipation
   b. Review diarrhea/vomiting protocols—clear liquids, when to come to the clinic. **Refer to "GE - Gastroenteritis" on page 427**.
3. Discuss that rectal temperature is a reliable method of temperature measurement in infants.
4. Discuss the care of the circumcised and uncircumcised penis.
5. Discuss infant hygiene, e.g., bathing, avoidance of powders, skin and nail care, vaginal discharge/bleeding.

CHI-L LITERATURE

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

STANDARDS:

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

CHI-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.

e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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, including cereal, should not be fed from a bottle or infant feeder but from a spoon.
2. Review breastfeeding: emphasize feeding in a semi-sitting position, on demand or every 3–4 hours and discuss current information on the use of vitamin and iron supplements when breastfeeding. Explain nursing caries and otitis media relationship to feeding.
3. Review formula preparation and storage and proper technique and position for bottle feeding. Emphasize the importance of bottle feeding with iron-fortified formula. Explain that warming bottles in the microwave may result in burns to the mouth.
4. Discuss age appropriate intake (ounces/day), appropriate weight gain, and stress the dangers of overfeeding.
5. Discuss weaning, transition from bottle to cup. Emphasize the effects of "baby bottle tooth decay." Discuss the use of a cup for water/milk, limit juice to 4-6 oz. per day.
6. Discuss waiting 3–4 days between additions of new foods to identify food allergies. Serve solids 3–4 times per day.
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, e.g., 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 (e.g., distraction for the 6 month old). Praise good behavior.
4. Encourage stimulation of the infant (hold, cuddle, play, read, talk, sing to the baby, and play age appropriate games e.g., pat-a-cake, peek-a-boo).
5. Encourage sibling participation in care of the infant while giving siblings attention as well.
6. Discuss the importance of a bedtime routine and self-consoling of baby. Discuss comfort objects such as stuffed animals or blankets as appropriate to the age of the infant.
7. Discuss separation anxiety and selecting safe child care settings as appropriate.
8. Encourage consistent parenting. Discuss the importance of limiting rules and setting routines. Do not allow hitting, biting, aggressive behavior.
9. Stress importance of regular well child care and immunizations.
10. Review the community resources available for help in coping with an infant. (WIC, finances)
11. Discuss family planning. Discuss folic acid if considering future pregnancy.

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. Discuss that shaking a baby can cause permanent brain damage or death.
3. 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).
4. 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. As appropriate, encourage safe exploration. Discuss siblings reactions to baby's exploration.
5. Explain that walkers are a source of serious injury and often delay walking.
6. Explain that SIDS is decreased by back or side lying, by keeping the infant too warm, and by not smoking in the home or car.
7. Emphasize the importance of learning first aid and CPR. Review emergency procedures for home and child care.
8. Child-proof the home. **Refer to "HPDP-S Safety and Injury Prevention" on page 483**.
    a. Burn safety: Keep hot liquids, cigarettes and other hot objects out of the infant's reach, cover outlets, test temperature of bath and set water heater to <120°F, turn pot handles to the back of the stove and use back burners preferentially, don't leave heavy objects or hot liquids on tablecloths, avoid dangling cords (curling irons, irons, coffee pots, etc.), avoid direct sunlight, limit sun exposure, use sunscreens hats and protective clothing.
    b. Choking safety: Review choking hazards and the importance of keeping small objects out of the child's reach (anything that will fit into a toilet paper roll), cut food in small pieces, review foods that pose a choking hazard.
    c. Water safety: Review drowning and the importance of never leaving the child unattended in the bath, keeping toilet lids down and bathroom doors closed, and emptying buckets.
    d. Poison safety: Emphasize the importance of child locks on cabinets and keeping potentially dangerous substances, including medications and objects out of the child's reach. Keep poison control number handy.
    e. Electrical safety: 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.
    f. Fall safety: Lower crib mattress as child becomes more mobile, keep a hand on the child when on high places.

g. Infection safety: Encourage frequent hand washing and washing of toys to prevent the spread of infections.

h. Play safety: Discuss street safety and the use of personal protective equipment like bicycle helmets. Avoid toys that are choking hazards or are sharp.

9. Emphasize the importance of carefully selecting child-care settings to ensure child safety. Discuss the importance of never leaving the infant alone with young siblings or pets.

10. Discuss lead hazards as appropriate.

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. Don't feed directly from jars or warm jars/ bottles in microwave.
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 months 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, e.g., 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 babies 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. Who will give you cues to readiness when they open their mouths when they see something coming
    c. Who will close lips over a spoon
    d. Who will keep food in their mouth instead of spitting it out
    e. Who 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 Prevention" on page 358, "OM-P Prevention" on page 648.**
2. Explain readiness signs of weaning that the infant may display.
3. Explain the process of weaning, e.g., replace one feeding at a time with solids or cup.
4. Explain social ways to replace breastfeeding or bottle-feeding, e.g., 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-CAR CAR SEATS AND AUTOMOBILE SAFETY

OUTCOME: The patient/family will understand measures that will improve car safety.

STANDARDS:

1. Stress the use of a properly secured car seat EVERY TIME the toddler rides in a vehicle. The car seat should be in the middle of the back seat of the vehicle.
2. Explain that the car seat should be rear-facing if the toddler is <20 pounds; if >20 pounds, the car seat can be forward-facing.
3. Discuss the requirement of a NTSB approved car seat.
4. Explain the dangers posed by things that might divert attention from driving, such as smoking, cell phone use, eating, CDs and radios, etc.
5. Emphasize the importance of never driving while under the influence of alcohol, sedatives, and/or street drugs.
6. Emphasize not to leave infant/children unattended in a vehicle (motor running, not running, keys in car) due to potential incidents; e.g., vehicle gears shifted and car goes in motion, electric windows cause injury to child, keys locked in vehicle with child, heat/cold exposure, abduction or child wandering away.

CHT-ECC EARLY CHILD CARIES

OUTCOME: The patient/family will understand the importance of good oral hygiene.

STANDARDS:

1. Discuss prevention of tooth decay (early childhood caries) by proper use of bottles, e.g., no bottles in bed, no propping of bottles, weaning by 12 months of age, nothing in the bottle except formula, breastmilk or electrolyte solution.
2. Review oral hygiene habits. Discuss that the whole family should practice good oral hygiene. Explain the methods of infant oral hygiene, e.g., use of a soft washcloth, soft tooth brush, or infant tooth cleaner to clean the gums/teeth.
3. Discuss, as appropriate, fluoride supplementation and the indications for fluoridated toothpaste and when non- fluoridated tooth paste should be used.
4. Discuss teething as appropriate.
5. Discuss the importance of regular dental examinations.

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, to screen for disease, and to 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 will 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 sleep habits and transition object for sleep. Explain that children in this age group typically sleep through the night.
4. Discuss toilet training methods and indicators of toilet training readiness, e.g., the ability to walk, complaining of wet or dirty diapers, asking to go to the toilet. Explain that toilet training should be delayed until the child is showing signs of toilet training readiness. Explain that curiosity about genitals is normal and to be expected.
5. Discuss language development, e.g. a typical 2 year old should be able to make 2 word sentences and are 50% understandable.
6. Review the importance of allowing for positive emotional growth. Touch is still important. Fears may develop during this time.
7. Review the need for good dental hygiene.
8. Discuss the need for continued well child care.

CHT-L LITERATURE

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

STANDARDS:

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

CHT-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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 meals per day. Encourage a relaxed mealtime atmosphere.
3. Review the dangers posed by continued use of the bottle beyond one year of age, e.g., baby bottle tooth decay, elongated midface, delayed speech, ear infections.

Refer to "OM-P Prevention" on page 648 and "ECC-P Prevention" on page 358.

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 and offer a variety of foods (e.g., fruit, veggies, lean meats, and whole grains). Limit foods such as candies, cookies, etc.
8. Discuss that juice should be limited to less than 8 oz./day

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. Toddlers still need to be held and cuddled. The personality of the toddler will dictate the degree of this need.
2. Discuss the common toddler behaviors that can cause parental frustration—constant demands, saying "no," struggle for autonomy, unwillingness to share, and boundless energy. Help the child to express emotions.
3. Discuss the parental need for sharing the toddler experience. Encourage the importance of talking with the toddler and helping him/her to express feelings.
4. Discuss age appropriate disciplinary techniques as increasing mobility increases the risk of injury (distraction, time-out). Encourage parents/caregivers to set limits and praise good behavior. Discuss that hitting, biting, and aggressive behaviors are common in this age group and require consistent parenting and disciplinary techniques.
5. Reinforce the need for adult companionship, periodic freedom from child-rearing responsibilities, and nurturing the marital relationship. Show affection in the family.

6. Stress that weariness, frustration, and exasperation with a toddler are normal. Discuss mechanisms for dealing with frustration.
7. Provide stimulating activities (e.g., 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.
8. Discuss that drinking and smoking in the presence of children may promote this behavior in the child.
9. Discuss that children who witness violent or abusive behaviors may mimic these behaviors.

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. Encourage parents to check for hazards at floor level. Discuss the need to child-proof the home e.g., safety locks, stair gates, window guards. Check windows and screens to assure that the toddler cannot push them out, etc.
2. Review continued need for child safety seats in automobiles. Avoid child safety seats in the front seat of any car with air bags. (As of December 2005 the American Academy of Pediatrics recommends that children remain in child safety seats until the age of 8 years AND 80 pounds.) **Refer to "CHT-CAR Car Seats and Automobile Safety" on page 199**.
3. Emphasize the importance of carefully selecting child-care settings to assure child safety. Never leave toddlers alone with young children or pets.
4. Child-proof the home. **Refer to "HPDP-S Safety and Injury Prevention" on page 483.**
    a. Burn safety: Keep hot liquids, cigarettes and other hot objects out of the infant's reach, cover outlets, test temperature of bath and set water heater to <120°F, turn pot handles to the back of the stove and use back burners preferentially, don't leave heavy objects or hot liquids on tablecloths, avoid dangling cords (curling irons, irons, coffee pots, etc.), avoid direct sunlight, limit sun exposure, use sunscreens, hats, and protective clothing.
    b. Choking safety: Review choking hazards and the importance of keeping small objects out of the child's reach (anything that will fit into a toilet paper roll, balloons, coins), cut food in small pieces, review foods that pose a choking hazard (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). Encourage CPR training.

c. Water safety: Review drowning and the importance of never leaving the child unattended in the bath, keeping toilet lids down and bathroom doors closed, and emptying buckets.

d. Poison safety: Emphasize the importance of child locks on cabinets and keeping potentially dangerous substances, including medications and objects out of the child's reach. Keep poison control number handy.

e. Electrical safety: 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.

f. Infection safety: Encourage frequent hand washing and washing of toys to prevent the spread of infections.

g. Play safety: Discuss street safety and the use of personal protective equipment like bicycle helmets. Avoid toys that are choking hazards or are sharp. Wash hands often; clean toys. Discourage independent operation of any motorized vehicle, including electrical vehicles. Encourage play and safe exploration.

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 months 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, e.g., 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 babies 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. Who will give you cues to readiness when they open their mouths when they see something coming
    c. Who will close lips over a spoon
    d. Who will keep food in their mouth instead of spitting it out
    e. Who 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, e.g., 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 - Tobacco Use" on page 828.**

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, e.g., replace one feeding at a time with solids or cup.
4. Explain social ways to replace breastfeeding or bottle-feeding, e.g., 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-CAR CAR SEATS AND AUTOMOBILE SAFETY

OUTCOME: The patient/family will understand measures that will improve car safety.

STANDARDS:

1. Stress the use of a properly secured, car seat EVERY TIME the preschooler rides in a vehicle.
2. Explain that the youngest child should be restrained in a car seat in the middle of the back seat of the vehicle.
3. Discuss the requirement of a NTSB approved car seat.
4. Explain the dangers posed by things that might divert attention from driving, such as smoking, cell phone use, eating, CDs and radios, etc.
5. Emphasize the importance of never driving while under the influence of alcohol, sedatives, and/or street drugs.
6. Emphasize not to leave infant/children unattended in a vehicle (motor running, not running, keys in car) due to potential incidents; e.g., vehicle gears shifted and car goes in motion, electric windows cause injury to child, keys locked in vehicle with child, heat/cold exposure, abduction or child wandering away.

CHN-ECC EARLY CHILD CARIES

OUTCOME: The patient/family will understand the importance of good oral hygiene.

STANDARDS:

1. Discuss the importance of not using baby bottles at all in this age group.
2. Review oral hygiene habits. Discuss that the whole family should practice good oral hygiene. Explain methods of infant oral hygiene, i.e. use of a soft washcloth, soft tooth brush, or infant tooth cleaner to clean the gums/teeth.
3. Discuss, as appropriate, fluoride supplementation and the indications for fluoridated toothpaste and when non- fluoridated tooth paste should be used.
4. Discuss teething as appropriate.
5. Discuss the importance of regular dental examinations.

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 will 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 LITERATURE

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

STANDARDS:

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

CHP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.

d. Evaluation of the patient's nutritional care outcomes.

e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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 will plan to provide a nurturing environment for this 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. Discuss age appropriate disciplinary techniques as increasing mobility increases the risk of injury (distraction, time-out). Encourage parents/caregivers to set limits and praise good behavior. Discuss that hitting, biting and aggressive behaviors are common in this age group and require consistent parenting and disciplinary techniques.

3. 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.
4. 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.
5. 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, e.g., television, music, conversations.
6. Discuss common fears of this age and the need for parental support.
7. Discuss that drinking and smoking in the presence of children may promote this behavior in the child.
8. Provide stimulating activities (e.g., sing, talk, read and color with the child) as alternatives to TV watching, which should not exceed one hour per day.
9. Discuss that children who witness violent or abusive behaviors may mimic these behaviors.

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, e.g., bike helmets, knee pads, elbow pads.
4. Emphasize the 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, e.g., private parts of the child's body.
6. Emphasize the importance of teaching the child how to safely cross the street.
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, e.g., 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 - Sun Exposure" on page 813.**

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, e.g., 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-AOD ALCOHOL AND OTHER DRUGS

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

STANDARDS:

1. Explain that adolescence is a high-risk time for using drugs and other risky behaviors.
2. Discuss ways to avoid situations where drugs or alcohol may be present and ways to resist peer pressure to use drugs, alcohol, and tobacco.
3. 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 the ability to think.
    d. Inhalants (huffing) can cause permanent brain damage.
    e. Diet pill use has been known to cause heart attacks and tachycardia with palpitations, impotence, and dizziness.
    f. Anabolic steroid can cause severe, long-lasting, and often irreversible negative health consequences. These drugs can stunt the height of growing adolescents, masculinize women, and alter sex characteristics of men. Anabolic steroids can lead to premature heart attacks, strokes, liver tumors, kidney failure, and serious psychiatric problems.
    g. All drugs of abuse impair judgment and dramatically increase the risk of behaviors that lead to AIDS, hepatitis, and other serious infections, many of which are not curable as well as increase the risk of injury
    h. Illicit drug use often results in arrest and imprisonment, creating a criminal record that can seriously limit the offender's ability to get jobs, education, or participate in government programs.
4. 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 breathe that often will limit the patient's ability to participate in normal activities such as sports or 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.

5. Explain that alcohol use is a major cause of illness and death in the United States and that addiction is common.

   a. Some of the risks of alcohol use are:

      i. Significant impairment of judgment and thinking ability leading to behaviors that the patient might not otherwise engage in, such as indiscriminate sex, fighting, and use of other drugs.

      ii. Liver disease, up to and including complete liver failure and death.

      iii. Arrest and imprisonment for alcohol-related behaviors such as drunken driving or fighting.

      iv. Loss of employment, destroyed relationships with loved ones, and serious financial problems.

6. Discuss resources available if the child/adolescent is currently using drugs, alcohol, or tobacco.

CHS-CAR CAR SEATS AND AUTOMOBILE SAFETY

OUTCOME: The patient/family will understand measures that will improve car safety.

STANDARDS:

1. Stress the use of a properly secured, booster car seat EVERY TIME the child under 80 pounds rides in a vehicle.
2. Explain that every child 80 pounds should be secured with a seat belt.
3. Explain that the youngest child should be restrained in a car seat in the middle of the back seat of the vehicle.
4. Discuss the requirement of a NTSB approved car seat.
5. Explain the dangers posed by things that might divert attention from driving, such as smoking, cell phone use, eating, CDs and radios, etc.

6. Emphasize the importance of never driving while under the influence of alcohol, sedatives, and/or street drugs.
7. Emphasize not to leave infant/children unattended in a vehicle (motor running, not running, keys in car) due to potential incidents; e.g., vehicle gears shifted and car goes in motion, electric windows cause injury to child, keys locked in vehicle with child, heat/cold exposure, abduction or child wandering away.

CHS-DC DENTAL CARIES

OUTCOME: The patient/family will understand the importance of good oral hygiene.

STANDARDS:

1. 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.
2. Explain that the frequency of carbohydrate consumption increases the rate of acid attacks, thereby increasing the risk of dental decay. **Refer to "DC-N Nutrition" on page 309.**
3. 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.
4. Explain that the use of fluoride strengthens teeth and may rebuild the early damage caused by bacteria/acid attacks. Explain that the most common source of fluoride is unfiltered, fluoridated tap 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.
5. As appropriate, discuss sealants as an intervention to prevent dental caries.

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. Discuss school transitions and the need to become responsible for school attendance, homework and as appropriate, course selection. Encourage participation in school activities.
4. Encourage active participation of the child in time management to get chores, school work, and play accomplished.
5. Encourage the identification of and pursuit of talents.
6. Review the increasing importance of hygiene.
7. Discuss prepubescent body changes and the accompanying emotions.
8. Review the information needed to explain menses and nocturnal emissions, as appropriate.
9. Encourage age-appropriate discussions of sexuality, birth control and sexually transmitted infections. **Refer to "CHS-SX Sexuality" on page 220.**
10. Discuss ways to resist peer pressure.

CHS-L LITERATURE

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

STANDARDS:

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

CHS-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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 three nutritious meals a day and healthy snacks.
3. Encourage parents to read food and beverage labels and then make healthy choices, e.g., fruits, vegetables; less breads, cereals, grains; only lean meat, chicken, fish, only low-fat dairy products.
4. Emphasize that high fructose corn syrup is widely used to sweeten prepared foods and beverages and contributes to obesity.
5. 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.
6. 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.
7. Encourage parents to model healthy nutritional habits and to eat as a family as often as possible.
8. Encourage maintenance of a healthy weight with good nutrition and physical activity.

CHS-PA PARENTING

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

STANDARDS:

1. Discuss how peer influence becomes increasingly important. Anticipate challenges to parental authority.
2. Discuss the importance of listening and communicating.
3. Emphasize that school is very important to children of school age. Encourage parents to show interest in school activities.
4. 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.
5. 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.
6. Discuss the importance of listening to the school aged child and showing interest in the child's activities.
7. Discuss that the preteen needs affection and praise for good behavior.
8. Emphasize the importance of establishing realistic expectations, clear limits, and consequences. Discuss that the parent preteen relationship will likely be better if the parent minimizes criticism, nagging, and negative messages. Emphasize the importance of consistency in parenting.
9. Emphasize the importance of knowing the child's friends and their families. Discuss monitoring for alcohol, drug and tobacco use as well as sexual activity.
10. Discuss that drinking and smoking in the presence of children may promote this behavior in the child.
11. Discuss that drinking and smoking in the presence of children may promote this behavior in the child.
12. Discuss that children who witness violent or abusive behaviors may mimic these behaviors.
13. Emphasize the importance of modeling respect, family values, safe driving practices, and healthy behaviors.
14. Discuss that guns should be handled responsibly. Encourage gun safes/gun locks or removing guns from the home as appropriate.

15. Refer to community resources as appropriate.

CHS-S SAFETY AND INJURY PREVENTION

OUTCOME: The parent(s) will identify safety concerns and will 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. Discuss home safety rules.
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, e.g., helmets, knee and elbow pads for bicycling and roller blading; life vests for water sports; helmets and protective body gear for horseback riding.
6. Discuss learning to swim to reduce the risk of drowning death and never using drugs or alcohol while swimming.
7. Encourage gun safety programs. Discuss safe storage of guns e.g., gun safes/gun locks or removing guns from the home as appropriate.
8. Encourage the use of sunscreen to reduce the risk of skin cancer. **Refer to "SUN - Sun Exposure" on page 813.**

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 will 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, e.g., 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 - Tobacco Use" on page 828.**

CHS-SOC SOCIAL HEALTH

OUTCOME: The patient/family will understand factors in developing social competence.

STANDARDS:

1. Encourage the pre-teen to learn about the teen's personal strengths and engage in activities to build upon these. Encourage taking on new challenges to build confidence.
2. Discuss the importance of a mentor or trusted adult to discuss feelings and ideas. This is especially true if things do not seem to be going well.
3. Discuss mechanisms to recognize and deal with stress. Learn to recognize self-destructive behaviors and to seek help for feelings of hopelessness.
4. Discuss the influence of peer pressure and mechanisms for resisting negative peer pressure.
5. Discuss the importance of respecting the rights of others.
6. Discuss the importance of listening and communicating.
7. Discuss increased independence in decision making, and taking on new responsibilities.
8. As appropriate discuss athletic conditioning.
9. Discuss physical/emotional health:
   a. Sleep about 8 hours per night.

b. Engage in physical activity 30-60 min. 3+ times per week.
c. Drink plenty of fluids (especially water).
d. Maintain a healthy weight.
e. Avoid loud music.

10. Discuss the importance of time management to keep all aspects of life balanced:
    a. Spiritual/cultural needs
    b. Family activities (including household chores)
    c. School activities
    d. Social activities
    e. Community activities
    f. Sports and exercise
    g. Physical/emotional health
11. Refer to community resources as appropriate.

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. Discuss the importance of identifying an adult (such as a healthcare professional) who can give accurate information about puberty, sexual development, contraception, and sexually transmitted diseases.
2. 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.
3. Discuss that early maturity can often lead to self esteem issues (e.g., depression, isolation, unrealistic body image, eating disorders, and sexual promiscuity).
4. Discuss as appropriate the anatomy and physiology of the male/female reproductive tract. Discuss that as a rule girls mature earlier than boys. **Refer to "HPDP-SX Sexuality" on page 486**.
5. Explain that as a general rule, menarche occurs within two years of thelarche (breast development).
6. Discuss the elements of a positive, nurturing interpersonal relationship versus a potentially abusive relationship.

7. Review the physical and emotional benefits of and encourage abstinence (e.g., 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). Explain that it is normal to have sexual feelings but that having sex should be delayed. Detail some ways that the preteen could say "no" to having sex.
8. Discuss abstinence, contraception, and safer sex (including correct use of latex condoms) if sexually active.
9. As appropriate, discuss any concerns about feelings for persons of the same or opposite sex.
10. 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 will 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, e.g., 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 - Tobacco Use" on page 828.**

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. Inhalants (huffing) can cause permanent brain damage.
    e. Diet pill use has been known to cause heart attacks and tachycardia with palpitations, impotence and dizziness.
    f. Anabolic steroid can cause severe, long-lasting, and often irreversible negative health consequences. These drugs can stunt the height of growing adolescents, masculinize women, and alter sex characteristics of men. Anabolic steroids can lead to premature heart attacks, strokes, liver tumors, kidney failure and serious psychiatric problems.
    g. 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.
    h. 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 are lot of things the patient may prefer to do with that much money.)

d. Cancer of the lung, bladder, and throat (smoking) as well as 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-CAR AUTOMOBILE SAFETY

OUTCOME: The patient/family will understand measures that will improve car safety.

STANDARDS:

1. Discuss the importance of using a seat belt when traveling in a vehicle.
2. Explain that the youngest child should be restrained in a car seat in the middle of the back seat of the vehicle.
3. Explain the dangers posed by things that might divert attention from driving, such as smoking, cell phone use, eating, CDs and radios, etc.
4. Emphasize the importance of never driving while under the influence of alcohol, sedatives, and/or street drugs.
5. Discuss the dangers in riding on the outside of the vehicle, such as in the back of a pick-up truck, on the hood of the vehicle, or on running boards of a vehicle.
6. Emphasize not to leave sibling/infant/child unattended in a vehicle (motor running, not running, keys in car) due to potential incidents; e.g., vehicle gears shifted and car goes in motion, electric windows cause injury to child, keys locked in vehicle with child, heat/cold exposure, abduction, or child wandering away.

CHA-DC DENTAL CARIES

OUTCOME: The patient/family will understand the importance of good oral hygiene.

STANDARDS:

1. 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.
2. Explain that the frequency of carbohydrate consumption increases the rate of acid attacks, thereby increasing the risk of dental decay. **Refer to "DC-N Nutrition" on page 309.**
3. 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.
4. Explain that the use of fluoride strengthens teeth and may rebuild the early damage caused by bacteria/acid attacks. Explain that the most common source of fluoride is unfiltered, fluoridated tap 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.
5. As appropriate, discuss sealants as an intervention to prevent dental caries.
6. Discuss that tobacco use increases the risk of tooth decay.

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. Discuss school transitions and the need to become responsible for school attendance, homework and as appropriate, course selection. Encourage participation in school activities.
4. Encourage active participation of the child in time management to get chores, school work, and play accomplished.
5. Encourage identification of and pursuit of talents.
6. Review the increasing importance of hygiene.
7. Discuss prepubescent/pubescent body changes and the accompanying emotions.
8. Review the information needed to explain menses and nocturnal emissions, as appropriate.
9. 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.
10. Explain that puberty and the associated growth spurt begins and ends at an earlier age in girls than in boys.

CHA-L LITERATURE

OUTCOME: The patient/family will receive literature about adolescent health issues.

STANDARDS:

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

CHA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:

a. Assessment of the nutrition related condition.
b. Identification of the patient's nutritional problem.
c. Identification of a specific nutrition intervention therapy plan.
d. Evaluation of the patient's nutritional care outcomes.
e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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 "HPDP-N Nutrition" on page 483**.
2. Review the basics of a nutritious diet. Teach the teen to make healthy food choices. Emphasize the role peers play in food intake and ways to resist negative peer pressure.
3. Encourage three nutritious meals a day and healthy snacks.
4. Encourage parents to read food and beverage labels and then make healthy choices, e.g., fruits, vegetables; less breads, cereals, grains; only lean meat, chicken, fish, only low-fat dairy products.
5. Emphasize that high fructose corn syrup is widely used to sweeten prepared foods and beverages and contributes to obesity. Relate the risk of diabetes to obesity.
6. 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.
7. Encourage parents to model healthy nutritional habits and to eat as a family as often as possible.
8. Encourage maintenance of a healthy weight with good nutrition and physical activity.
9. Emphasize the importance of not skipping meals, especially breakfast.
10. Discuss calcium intake, including its role in preventing osteoporosis.

11. Discuss the risk of anorexia and bulimia in adolescence. Discuss the 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 the importance of spending quality time with the teenager. Emphasize that teens need praise for good behavior. Discuss the importance of establishing realistic expectations, clear limits, and consequences. Discuss that the parent teen relationship will likely be better if the parent minimizes criticism, nagging and negative messages. Emphasize the importance of consistency in parenting.
4. Emphasize that school activities are often very important to teenagers. Encourage parents to show interest in school activities.
5. Discuss how fluctuating hormone levels affect emotions. Be alert for significant changes in behavior which may indicate depression.
6. Encourage open lines of communication between parents and community role models.
7. Provide an environment that allows for increased independence and decision-making. Emphasize the importance of completing adequate education.
8. Discuss the importance of respecting the teen's need for privacy.
9. Emphasize the importance of knowing the child's friends and their families. Discuss monitoring for alcohol, drug and tobacco use as well as sexual activity.
10. Discuss that drinking and smoking in the presence of children may promote this behavior in the child.
11. Discuss that children who witness violent or abusive behaviors may mimic these behaviors.
12. Emphasize the importance of modeling respect, family values, safe driving practices, and healthy behaviors.
13. Discuss that guns should be handled responsibly. Encourage gun safes/gun locks or removing guns from the home as appropriate.

14. Explain the importance of teaching adolescents to respect others and accept their differences. Discourage bullying and belittling behaviors.
15. Refer to community resources as appropriate.

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 - Alcohol and Other Drugs" on page 42** and **"TO - Tobacco Use" on page 828**.
2. Review that motor vehicle crashes are the most common cause of injury and death in this age group. Encourage the use of seat belts. Promote driving education courses and the importance of following the speed limit and other rules of the road. Refer to **"CHA-CAR Automobile Safety" on page 223.**
3. Promote use of seat belts and other personal protective equipment, e.g., helmets, knee pads, elbow pads, mouth guards.
4. Promote the safe use of all recreational vehicles (e.g., all terrain vehicles (ATVs), snow machines, boats, horses), refer to community resources as appropriate.
5. Discuss learning to swim to reduce the risk of drowning death and never using drugs or alcohol while swimming.
6. Discourage sun tanning or use of tanning beds. Encourage the use of sunscreen to decrease the risk of skin cancer. **Refer to "SUN - Sun Exposure" on page 813**.
7. Review personal safety strategies, e.g., sexual molestation, strangers, chat rooms, etc. Discuss home safety rules.
8. 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" as 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, e.g., 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 - Tobacco Use" on page 828.**

CHS-SOC SOCIAL HEALTH

OUTCOME: The patient/family will understand factors in developing social competence.

STANDARDS:

1. Encourage the pre-teen to learn about the teen's personal strengths and engage in activities to build upon these. Encourage taking on new challenges to build confidence.
2. Discuss the importance of a mentor or trusted adult to discuss feelings and ideas. This is especially true if things do not seem to be going well.
3. Discuss mechanisms to recognize and deal with stress. Learn to recognize self-destructive behaviors and to seek help for feelings of hopelessness.
4. Discuss the influence of peer pressure and mechanisms for resisting negative peer pressure.
5. Discuss the importance of respecting the rights of others.
6. Discuss the importance of listening and communicating.

7. Discuss increased independence in decision making, and taking on new responsibilities.
8. As appropriate discuss athletic conditioning.
9. Discuss physical/emotional health:
   a. Sleep about 8 hours per night.
   b. Engage in physical activity 30-60 min. 3+ times per week.
   c. Drink plenty of fluids (especially water).
   d. Maintain a healthy weight.
   e. Avoid loud music.
10. Discuss the importance of time management to keep all aspects of life balanced:

    Spiritual/cultural needs
   a. Family activities (including household chores)
   b. School activities
   c. Social activities
   d. Community activities
   e. Sports and exercise
   f. Physical/emotional health
11. Refer to community resources as appropriate.

CHA-SX SEXUALITY

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

STANDARDS:

1. Discuss the importance of identifying an adult (such as a healthcare professional) who can give accurate information about puberty, sexual development, contraception, and sexually transmitted diseases.
2. Explain the physical changes that result from increased hormonal activity. Discuss that this is happening at an earlier age and may produce an expectation of a more mature behavior which is often unrealistic.
3. Discuss the elements of a positive, nurturing interpersonal relationship versus a potentially abusive relationship.
4. Review the need for continued information sharing regarding sexuality, birth control and STIs.

5. Discuss as appropriate the anatomy and physiology of the male/female reproductive tract. **Refer to "HPDP-SX Sexuality" on page 486.**
6. Review the physical and emotional benefits of and encourage abstinence (e.g., 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). Explain that it is normal to have sexual feelings but that having sex should be delayed. Detail some ways that the teen could say "no" to having sex.
7. As appropriate discuss birth control and sexually transmitted infection prevention.
8. Discuss abstinence, contraception and safer sex (including correct use of latex condoms) if sexually active.
9. As appropriate, discuss any concerns about feelings for persons of the same or opposite sex.
10. 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, e.g., 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 - Tobacco Use" on page 828.**

CB - Childbirth

CB-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the anatomy of the female reproductive system in pregnancy, e.g., labia, vagina, cervix, uterus, placenta, umbilical cord, amniotic sac and fluid, pelvic muscles, and bones.
2. Explain that "labor" is the contraction of the uterine muscles accompanied by progressive dilation and effacement (opening) of the cervix. Explain that contractions may occur without changes to the cervix and that true labor does not take place until the cervix begins to open.
3. Relate the changes that occur in the female reproductive system as labor is initiated and progresses:
    a. First Stage
        i. The early or latent phase is characterized by irregular contractions or regular contractions without changes in the cervix. Emphasize that this may last for days or weeks.
        ii. The active phase is characterized by regular contractions with cervical dilatation.
        iii. The transition phase is the final part of the first stage of labor during which the cervix becomes fully dilated.
    b. The Second Stage starts when the cervix is fully dilated and ends at the time of delivery of the baby during which the baby passes through the birth canal.
    c. The Third Stage of labor is the time between the delivery of the baby to the time of delivery of the placenta.

CB-C COMPLICATIONS

OUTCOME: The patient will understand that a normal labor and delivery has the potential to become abnormal and complications may occur at any time.

STANDARDS:

1. Explain that complications may necessitate the use of special equipment, medications and possibly cesarean section to facilitate safe and rapid delivery of the baby.

2. Explain that it is impossible to predict who will or will not have a complication during labor.
3. Explain that despite appropriate medical care, not all pregnancies result in normal/ healthy babies.

CB-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 pregnancy and childbirth may be influenced by choices related to health and lifestyles, e.g., diet, exercise, sleep, stress management, hygiene, full participation in the medical plan.
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 healthcare provider to determine if there are interactions with pregnancy or 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. Explain that sweat lodges, saunas, hot tubs, or other prolonged heat may be harmful to a developing baby. 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.

CB-EQ EQUIPMENT

OUTCOME: The patient/family will have a basic understanding of the equipment utilized to monitor childbirth.

STANDARDS:

1. Discuss the use and benefits of equipment to monitor labor.
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 there are concerns.

CB-EX EXERCISES, RELAXATION & BREATHING

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

STANDARDS:

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

CB-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up for routine postpartum and newborn visits.

STANDARDS:

1. Emphasize the importance of keeping appointments for routine postpartum and newborn follow-up. Explain that the purpose of follow-up appointments is to detect anything which could become a problem, and that the mother and the baby should keep all appointments even if everything seems to be fine.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

CB-L LITERATURE

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

STANDARDS:

1. Provide parent/family with literature on childbirth.
2. Discuss the content of the literature.

CB-LB LABOR SIGNS

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

STANDARDS:

1. Explain the difference between early labor and false labor (Braxton-Hicks contractions). **Refer to** **"CB-AP Anatomy and Physiology" on page 232**.
2. Emphasize the importance of immediate evaluation for any suspected amniotic fluid leak. Explain that prolonged rupture of membranes can be dangerous to the baby and the mother.
3. Discuss the appropriate time for this patient to present to the hospital as related to frequency and duration of contractions, etc. (This will vary with circumstances; for example, a patient who lives far away may need to start for the hospital sooner than one who lives near.)
4. Explain that the patient should come to the hospital immediately for rupture of membranes, heavy bleeding, severe headaches, severe swelling, or decreased fetal movement.

CB-M MEDICATIONS

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

STANDARDS:

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

CB-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.

CB-OR ORIENTATION

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

STANDARDS:

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

CB-PM PAIN MANAGEMENT

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

STANDARDS:

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

CB-PRO PROCEDURES, OBSTETRICAL

OUTCOME: The patient will understand the procedures utilized during labor, delivery, and the immediate postpartum period.

STANDARDS:

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

CB-RO ROLE OF LABOR AND DELIVERY PARTNER/COACH

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

STANDARDS:

1. Explain that the role of the partner/coach during the stages of labor and birth is to help the mother focus and practice techniques and to assist in comfort measures.
2. **Refer to "PN - Prenatal" on page 718, "PP - Postpartum" on page 701.**

CB-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 collection method.

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 and instructions for the test.
5. Discuss the meaning of the test results, as appropriate.

CB-VBAC VAGINAL BIRTH AFTER CESAREAN SECTION

OUTCOME: The patient and labor partner/coach will understand that VBAC is possible in some cases, as well as the processes, risks, and benefits associated with VBAC.

STANDARDS

1. Explain that there is a high success rate of VBAC.
2. Explain the importance of having prior medical records to determine whether the patient is a candidate for VBAC.
3. Discuss that there is a faster recovery after VBAC than a repeat C-section.
4. Explain that close monitoring of the labor process will be necessary and that if complications arise a C-section may be necessary.
5. Explain that significant risks from VBAC include uterine rupture, failure to progress in labor, and C-section.
6. Explain that VBAC is not available in all institutions or to all patients.

CKD - Chronic Kidney Disease

CKD-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of where the kidneys are located in the body and their function.

STANDARDS:

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

CKD-C COMPLICATIONS

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

STANDARDS:

1. Explain that CKD is progressive in nature.
2. Explain that anemia is a common consequence of chronic kidney failure due to a decrease in erythropoietin production from the kidneys or there may be a lack of iron in the blood.
3. Explain how uncontrolled hypertension hurts the blood vessels in the kidneys and increases the risk for cardiovascular disease.

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

CKD-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving optimal physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

CKD-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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in the medical plan.
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 healthcare 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.

CKD-DIA DIALYSIS

OUTCOME: The patient/family will understand the process, risks, and benefits of hemodialysis and events that may result from refusal of hemodialysis.

STANDARDS:

1. Explain the dialysis procedure 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. Explain hemodialysis:
   a. Hemodialysis is the use of an artificial filtering of blood by a machine, removing metabolic wastes and excess fluids from the body.
   b. This procedure is usually initiated three times per week. Each session is usually three to four hours at a hemodialysis center.
   c. A fistula, a surgical connection of major blood vessels, is usually placed in the arm prior to the start of dialysis. A temporary placement may be established in other sites of the body such as the neck when an emergent condition arises.
3. Discuss the expected patient/family involvement in the care required following dialysis.
4. Explain that infections are common in dialysis patients and that the patient/family should report all elevations in body temperature to the dialysis staff. Infection,

particularly at the site may require immediate hospitalization for IV antibiotic therapy.

5. Explain that deviations from prescribed dietary and fluid restrictions may result in acute metabolic problems, which must be addressed by the dialysis unit.
6. Explain that even with proper dialysis, patients may experience fluid imbalances and that all shortness of breath, unusual swelling, dizziness, etc. should prompt immediate medical attention and evaluation.

CKD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the patient's specific type of chronic kidney disease (CKD). (Choose from the following standards that apply to this patient's specific chronic kidney disease process.)

STANDARDS:

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

CKD-EQ EQUIPMENT

OUTCOME: The patient/family will understand hemodialysis and equipment used for home dialysis.

STANDARDS:

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

CKD-LA LIFESTYLE ADAPTATIONS

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

STANDARDS

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

CKD-M MEDICATIONS

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

STANDARDS:

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

5. Explain that the patient's medications may change after starting dialysis (as appropriate).
6. Emphasize the importance of bringing all medications to medical appointments.

CKD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of chronic kidney disease.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CKD-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition and chronic kidney disease.

STANDARDS:

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

CKD-P PREVENTION

OUTCOME: The patient/family will understand how to prevent or slow progression of chronic kidney disease (CKD). The patient/family will understand how to prevent

complication(s) associated with vascular access placement, e.g., AV fistula, graft, or central line catheter.

STANDARDS:

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

CKD-PRO PROCEDURES

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

STANDARDS:

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

CKD-TE TESTS

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

STANDARDS:

1. Explain the specific test(s) ordered and collection method, e.g., blood urea nitrogen, creatinine, phosphorus, calcium, albumin, urinalysis, CBC.
2. Explain the necessity, benefits, and risks of the test(s) to be performed and how it relates to the course of treatment.

3. Explain any necessary preparation and instructions for the testing, e.g., fasting.
4. Explain the meaning of the test results and its impact on further treatment, as appropriate.
5. Describe the patient's current estimated GFR as it relates to the stages of CKD developed by the National Kidney Foundation, as it pertains to the patient's quality of life.

CKD-TX TREATMENT

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

STANDARDS:

1. Discuss the specific treatment plan for CKD including treatment to conserve renal function and eventual need for renal replacement therapy.
2. Emphasize the importance of fully participating to medications, dietary, and lifestyle changes that may impede the rate of progression of chronic kidney disease.
3. Discuss the treatment plan with patient/family; emphasize the importance of full participation with therapeutic regimen, even if the patient is asymptomatic.
4. Explain each possible renal replacement therapy:
    a. Hemodialysis
        i. Hemodialysis is the use of an artificial filtering of blood by a machine, removing metabolic wastes and excess fluids from the body.
        ii. This procedure is normally initiated three times per week. Each session is usually three to four hours at a hemodialysis center.
        iii. A fistula, a surgical connection of major blood vessels, is normally placed in the arm prior to the start of dialysis. A temporary placement may be established in other sites of the body such as the neck when an emergent condition arises.
    b. Peritoneal dialysis
        i. Peritoneal dialysis involves an artificial filtering of the blood by a bagged solution.
        ii. This form of dialysis removes metabolic wastes and excess fluids from the body. This is done through an exchange system via osmosis to remove water and diffusion for glucose exchange/waste removal.
        iii. This procedure is preformed on a daily basis at home.

iv. Each session is dependent on the two different types of peritoneal dialysis used.

- Intermittent Peritoneal Dialysis (IPD). This is normally completed once per day using multiple bags of dialysate, (bags of glucose fluids). A partner is usually needed.
- Continuous Cycling Peritoneal Dialysis (CCPD). This is normally a nocturnal procedure regulated by an infusion pump administering a set amount of dialysate exchange throughout the night.
- Continuous Ambulatory Peritoneal Dialysis (CAPD). This procedure is performed four times per day and there is fluid in the abdomen nearly 100% of the time. A partner is not necessary for this procedure.

c. Kidney transplant

i. Kidney transplantation is completed in end stage kidney disease when the glomerular filtration rate drops to 10 mL/min.

ii. Persons older then 50 years of age with poor health or history of cancer often can not receive a transplant.

iii. Children must receive an evaluation from a pediatric renal transplant team prior to receiving a transplant or being considered as a donor.

iv. After a renal transplant, the patient has a functioning donor kidney. Medications and regular medical evaluations will usually be required to prevent rejection.

v. It is important for patients to understand that anti-rejection medication must be taken as prescribed through out their life to prevent kidney rejection. Anti-rejection medications may have very unpleasant side effects.

vi. Patients with co-morbidities leading to initial kidney failure must be instructed to follow all prescribed regimens to avoid subsequent kidney failure.

vii. There is a possibility that a donor kidney may fail or be rejected even under ideal conditions.

5. Review with the patient/family the risks and benefits of each renal replacement therapy option and the consequences of refusing treatment.

CPM - Chronic Pain

CPM-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving optimal physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33.**

CPM-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

CPM-DP DISEASE PROCESS

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

STANDARDS:

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

CPM-EQ EQUIPMENT

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

STANDARDS:

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

CPM-EX EXERCISE

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

STANDARDS:

1. Review the different types of exercise including active and passive range of motion and strengthening.

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

CPM-FU FOLLOW-UP

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

STANDARDS:

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

CPM-IR INFORMATION AND REFERRAL

OUTCOME: The patient/family will receive information and referral for alternative or additional services as needed or desired.

STANDARDS:

1. Provide the patient/family with alternative or additional sources for care and services.
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

CPM-L LITERATURE

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

STANDARDS:

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

CPM-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

CPM-M MEDICATIONS

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

STANDARDS:

1. Review the patient's medication. Reinforce the importance of knowing the medication, dose, and dosing interval of medications.
2. Review common side effects, signs of toxicity, and drug/drug or drug/food interactions of medications.
3. Discuss the importance of taking medications as prescribed.
4. Emphasize the importance of taking medications as prescribed. If more medication is needed consult with the medical provider prior to increasing the dose of medication.
5. Discuss non-pharmacologic pain control measures.

CPM-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.

CPM-PSY PSYCHOTHERAPY

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

STANDARDS:

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

CPM-S SAFETY

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

STANDARDS:

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

CPM-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress may exacerbate the symptoms of chronic pain. This can set up a cycle of pain-stress which becomes self-sustaining and may escalate.
2. Explain that uncontrolled stress can interfere with the treatment of chronic pain.
3. Discuss that in chronic pain, uncontrolled stress may lead to depression or other mood disorders. **Refer to "CPM-PSY Psychotherapy" on page 253**.
4. Explain that effective stress management may reduce the severity of symptoms the patient experiences, as well as help improve the health and well-being of the patient.
5. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the severity of pain.
6. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
   a. Becoming aware of your own reactions to stress
   b. Recognizing and accepting your limits
   c. Talking with people you trust about your worries or problems
   d. Setting realistic goals
   e. Getting enough sleep
   f. maintaining a reasonable diet
   g. Exercising regularly
   h. Taking vacations
   i. Practicing meditation
   j. Practicing self-hypnosis
   k. Using positive imagery
   l. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   m. Participating in spiritual or cultural activities
7. Provide referrals as appropriate.

CPM-TE TESTS

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

STANDARDS:

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

CPM-TX TREATMENT

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

STANDARDS:

1. Discuss with the patient/family the possible appropriate nonpharmacologic pain relief measures, e.g., TENS units, heat, cold, massage, meditation, imagery, acupuncture, healing touch, traditional healer, hypnosis.
2. Discuss with the patient/family the possible appropriate pharmacologic pain relief measures. **Refer to "CPM-M Medications" on page 252.**
3. Discuss with the patient/family the possible appropriate procedural or operative pain management techniques, e.g., nerve block, intrathecal narcotics, local anesthesia.
4. Emphasize the importance of the patient/family's full participation in the development of a treatment plan.
5. As appropriate, discuss the implications of patient-provider contracts for pain medications.

CDC - Communicable Diseases

CDC-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy/physiology as it relates to the communicable disease.

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 communicable disease process or condition, as appropriate.
3. Discuss the impact of these changes on the patient's health or well-being.

CDC-C COMPLICATIONS

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

STANDARDS:

1. Discuss the common or significant complications associated with the communicable disease.
2. Discuss common or significant complications that may be prevented by full participation with the treatment regimen.
3. Discuss common or significant complications which may result from treatment(s).

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. **Refer to "IM - Immunizations" on page 547** (as appropriate)
2. Describe how the body is affected, the symptoms of the disease, and how long it may take for symptoms to appear.

CDC-EQ EQUIPMENT

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

STANDARDS:

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

CDC-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care.
2. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
3. Discuss the procedure for obtaining follow-up appointments, that follow-up appointments should be kept and the importance of continuing prescribed therapy.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and refer as appropriate.

CDC-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of communicable diseases.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, e.g., 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-HY HYGIENE

OUTCOME: The patient/family will understand good personal hygiene as an aspect of wellness and the prevention of communicable diseases.

STANDARDS:

1. Discuss bathing, daily dental hygiene and frequent hand washing in infection control.
2. Discuss the importance of covering the mouth when coughing or sneezing.
3. Discuss any hygiene habits that are specifically pertinent to this communicable disease.

CDC-L LITERATURE

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

STANDARDS:

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

CDC-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

CDC-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for communicable diseases.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CDC-N NUTRITION

OUTCOME: The patient/family will understand the need for balanced nutrition.

STANDARDS:

1. Review adequate fluid intake.
2. Discuss nutritional modifications as related to the specific communicable disease.

CDC-P PREVENTION

OUTCOME: The patient/family will understand preventive measures for disease spread.

STANDARDS:

1. Explain that there are vaccines or immunity against certain infections and/or diseases. **Refer to "IM - Immunizations" on page 547** (as appropriate)
2. Explain that certain infections can be dependent upon hygiene, social and/or environmental conditions. **Refer to "HPDP-HY Hygiene" on page 481.**
3. Discuss the 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 and patient. **Refer to "PM - Pain Management" on page 657.**
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-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, e.g., bowel preps, diet instructions, bathing.
4. Discuss pain management as appropriate.
5. Emphasize post-procedure management and follow-up.

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 and collection method.
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.

CDC-TX TREATMENT

OUTCOME: The patient/family will understand the treatment(s) proposed for the communicable disease.

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.

CHF - Congestive Heart Failure

CHF-C COMPLICATIONS

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

STANDARDS:

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

CHF-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33N**.

CHF-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

CHF-DP DISEASE PROCESS

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

STANDARDS:

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

CHF-EQ EQUIPMENT

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

STANDARDS:

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

5. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
6. Emphasize the importance of not tampering with any medical device.
7. Discuss as appropriate the proper use, care, and cleaning of medical equipment.
8. Discuss proper disposal of associated medical supplies.

CHF-EX EXERCISE

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

STANDARDS:

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

CHF-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of congestive heart failure.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up, e.g., any sudden weight gain.
5. Discuss the availability of community resources and support services and refer as appropriate.

CHF-HM HOME MANAGEMENT

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

STANDARDS:

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

CHF-L LITERATURE

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

STANDARDS:

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

CHF-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

CHF-M MEDICATIONS

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

STANDARDS:

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

CHF-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CHF-N NUTRITION

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

STANDARDS:

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

CHF-SM STRESS MANAGEMENT

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

STANDARDS:

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

CHF-TE TESTS

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

STANDARDS:

1. Explain the test ordered and collection method.
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 and instructions for the test.
5. Discuss the meaning of the test results, as appropriate.

CAD - Coronary Artery Disease

CAD-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family/caregiver will understand the process of developing an advance directive and its role in maintaining a sense of control in the patient's medical care and decisions.

STANDARDS:

1. Explain that patients may lose the ability to make their own decisions and an advance directive will be able to express the patient's desires prior to the loss of decision-making abilities.
2. Review the option of Advanced Directives/Living Will with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
3. Refer to appropriate services to assist the patient in making a living will, e.g., Social Services, Clergy, Lawyer.
4. **Refer to "ADV - Advance Directives" on page 40**.

CAD-C COMPLICATIONS

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

STANDARDS:

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

CAD-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

CAD-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

CAD-DP DISEASE PROCESS

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

STANDARDS:

1. Explain that coronary artery disease is the result of the buildup of plaque in the interior wall of the coronary artery.

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

CAD-EQ EQUIPMENT

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

STANDARDS:

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

CAD-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Assist the patient in developing a personal exercise plan. Explain that exercise should be consistent and of sufficient duration to obtain the desired outcome.
4. Encourage the patient to increase the intensity of the activity as the patient becomes more fit.
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Refer to community resources as appropriate.

CAD-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of coronary artery disease.

STANDARDS:

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

CAD-L LITERATURE

OUTCOME: The parent/family will receive literature about coronary artery disease.

STANDARDS:

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

CAD-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

CAD-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

CAD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of coronary artery disease.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CAD-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition and coronary artery disease.

STANDARDS:

1. Discuss the roles of heredity, exercise, and lifestyle habits including the relationship between diet and coronary artery disease, hypertension, elevated cholesterol, and obesity.
2. Explain which foods are sources of saturated fats and trans fatty acids. Encourage the reading of food labels: "free, low, reduced" fat and cholesterol, etc.
3. Discuss the benefits of omega-3 fatty acids such as tuna, salmon, herring, mackerel and the water-soluble fibers found in legumes, fruits, and bran.
4. Discuss an appropriate low fat diet and exercise plan to achieve optimal weight and improve or correct lipids. Refer to registered dietitian for MNT.
5. **Refer to "LIP - Hyperlipidemia/Dyslipidemias" on page 517.**

CAD-P PREVENTION

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

STANDARDS:

1. Discuss that prevention of coronary artery disease is far better than controlling the disease after it has developed.

2. Explain that consuming a diet low in fat, and controlling weight, lipid levels and blood pressure will help to prevent CAD.
3. Discuss that persons with uncontrolled diabetes, uncontrolled hypertension, and/or uncontrolled dyslipidemia are more likely to develop CAD. Stress the importance of controlling these disease processes. **Refer to "DM - Diabetes Mellitus" on page 318, "HTN - Hypertension" on page 524, "LIP - Hyperlipidemia/ Dyslipidemias" on page 517, "OBS - Obesity" on page 621.**

CAD-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that chest pain unrelieved by the prescribed regimen should be considered an emergency and prompt immediate medical evaluation.
2. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to "PM - Pain Management" on page 657.**
3. Explain that short-term use of narcotics may be helpful in pain management as appropriate.
4. Explain that other medications may be helpful to control the symptoms of pain.
5. Discuss non-pharmacologic measures that may be helpful with pain control.

CAD-PRO PROCEDURES

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

STANDARDS:

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

CAD-SM STRESS MANAGEMENT

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

STANDARDS:

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

CAD-TE TESTS

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

STANDARDS:

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

CAD-TX TREATMENT

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

STANDARDS:

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

CRN - Crohn's Disease

CRN-C COMPLICATIONS

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

STANDARDS:

1. Explain that some possible complications of Crohn's disease are stricture and fistulae formation, hemorrhage, bowel perforation, mechanical intestinal obstruction, and colorectal cancer, etc.
2. Explain that complications may be delayed, minimized, or prevented with prompt treatment of exacerbation.
3. Discuss the symptoms of exacerbation that trigger the need to seek medical attention, e.g., blood in the stool, unusual drainage, unusual abdominal pain, change in frequency of stools, fever.

CRN-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

CRN-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

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 healthcare provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges, may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

CRN-DP DISEASE PROCESS

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

STANDARDS:

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

CRN-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of Crohn's Disease.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

CRN-L LITERATURE

OUTCOME: The patient/family will receive literature about Crohn's disease.

STANDARDS:

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

CRN-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

CRN-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of Crohn's disease

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CRN-N NUTRITION

OUTCOME: The patient/family will understand the benefits of dietary modification in the management of bowel function.

STANDARDS:

1. Explain that fresh fruits, fresh vegetables, and dairy products should be avoided in the diet. Eat foods that are low in fats (fish oil recommended such as omega-3 fatty acids). Provide a list of foods for the patient to avoid, if available.
2. Explain that seasoning are usually poorly tolerated.
3. Explain to the patient/family that in severe cases, parenteral hyperalimentation may be necessary to maintain nutrition while allowing the bowel to rest.
4. Assist the patient/family in developing appropriate meal plans. Refer to registered dietitian for MNT.

CRN-P PREVENTION

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

STANDARDS:

1. Discuss the effects of a fatty, low fiber diet on the colon.
2. Provide and review a list of low fat, high fiber foods.

3. Assist the patient/family in meal planning that includes low fat, high fiber foods and avoids high fat, low fiber foods.
4. Explain that the etiology of Crohn's disease is unknown and there is no known prevention, but an appropriate diet may prevent or slow progression of the disease.

CRN-PM PAIN MANAGEMENT

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

STANDARDS:

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

CRN-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress can increase constipation or diarrhea, abdominal pain, and fatigue.
2. Explain that uncontrolled stress can interfere with the treatment of Crohn's disease.
3. Explain that effective stress management may reduce the adverse consequences of Crohn's disease, as well as help improve the health and well-being of the patient.
4. Explain that stress may cause inappropriate eating which will exacerbate the symptoms of Crohn's disease. **Refer to "CRN-N Nutrition" on page 281.**
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 healthy diet
g. Exercising regularly
h. Taking vacations
i. Practicing meditation, self-hypnosis, and positive imagery
j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
k. Participating in spiritual or cultural activities

6. Provide referrals as appropriate.

CRN-TE TESTS

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

STANDARDS:

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

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

CRN-TX TREATMENT

OUTCOME: The patient/family will understand the appropriate treatment for bowel disease

STANDARDS:

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

CRP - Croup

CRP-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy/physiology as it relates to croup.

STANDARDS

1. Discuss the anatomy/physiology of the airway.
2. Discuss changes to the anatomy/physiology as a result of croup and how this results in the symptoms seen in 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, e.g., rapid breathing, nasal flaring, retractions, stridor at rest; bluish color on the patient's lips or face; drooling, trouble swallowing; prolonged fever; dehydration, pulling at ears.
3. Discuss that croup can be a serious, life-threatening disease especially for young children and that serious complications should prompt immediate intervention (go to ER or clinic as appropriate). **Refer to "CRP-FU Follow-Up" on page 286.**

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 as indicated.
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, reflux, anomalies of

the airway, or foreign bodies in the airway. In rare instances *H flu* may be the cause of croup-like symptoms.

4. Explain that croup most often occurs in children between 6 months and 3 years of age during the cold season. 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. **Refer to "CRP-C Complications" on page 285.**

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/family will understand the importance of follow-up in the treatment of croup.

STANDARDS:

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

3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. 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/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. Providing a warm or cool humidifier (don't use a hot vaporizer)
    b. Providing a "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 LITERATURE

OUTCOME: The patient/family will receive literature about croup.

STANDARDS:

1. Provide the patient/family with literature on croup.

2. Discuss the content of the literature.

CRP-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

CRP-SHS SECOND-HAND SMOKE

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

STANDARDS:

1. Define “passive smoking” ways in which exposure occurs., e.g., smoldering cigarette, cigar, or pipe, smoke that is exhaled from active smoker, smoke residue on clothing, upholstery, carpets or walls.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, many other carcinogens (cancer causing substances). Explain the increased risk of illness in the croup patient when exposed to cigarette smoke either directly or via second-hand smoke.
3. 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.
4. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
5. Encourage smoking cessation or at least never smoking in the home or car. **Refer to “TO-QT Quit” on page 832.**

CF - Cystic Fibrosis

CF-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy/physiology as it relates to cystic fibrosis.

STANDARDS:

1. Discuss anatomy/physiology as it relates to cystic fibrosis and that it often is a multisystem disease.
2. Discuss changes to anatomy/physiology as a result of cystic fibrosis.
3. Discuss the impact of these changes on the patient's health or well-being.

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-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.

2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

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, e.g., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan.
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 healthcare 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 genetic disorder that is 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 as it applies to this patient.
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 the indications for and the benefits of prescribed medical equipment.
2. Discuss the types and features of medical equipment as appropriate.
3. Discuss and/or demonstrate proper use and care of medical equipment, participate in return demonstration by patient/family as appropriate.
4. Discuss the signs of equipment malfunction and the proper action in case of malfunction.
5. Emphasize the safe use of equipment, e.g., no smoking around O_2, use of gloves, electrical cord safety, and disposal of sharps.

CF-EX EXERCISE

OUTCOME: The patient/family/caregiver 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. Discuss medical clearance issues for physical activity.

2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Assist the patient in developing a personal exercise plan. Explain that exercise should be consistent and of sufficient duration to obtain the desired outcome.
4. Encourage the patient to increase the intensity of the activity as the patient becomes more fit.
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Refer to community resources as appropriate.

CF-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize that the treatment plan and full participation to it are the responsibility of the patient/family.
2. Discuss the procedure for obtaining follow-up appointments, that follow-up appointments should be kept and the importance of continuing prescribed therapy.
3. Encourage genetic counseling prior to starting a family.
4. Discuss the availability of community resources and support services. Refer as appropriate.

CF-L LITERATURE

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

STANDARDS:

1. Provide patient/family with literature on cystic fibrosis.
2. Discuss the content of the literature.

CF-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.

2. Discuss the risks, benefits and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

CF-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of cystic fibrosis.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CF-N NUTRITION

OUTCOME: The patient/family will understand the special nutritional requirements of 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 and/or salt 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. Explain that if the patient is lactose intolerant, sources of calcium other than milk may be necessary. Discuss other aspects of nutrition support as appropriate. Refer to a registered dietician for MNT or physician for specific information as appropriate.

CF-SHS SECOND HAND SMOKE

OUTCOME: The patient/family will understand the adverse health consequences associated with exposure to second-hand tobacco smoke and 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 harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, 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 person 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. **Refer to "TO-QT Quit" on page 832.**

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.
4. Explain the meaning of test results.

CF-TO TOBACCO (SMOKING)

OUTCOME: The patient/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 person 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. **Refer to "TO-QT Quit" on page 832.**
3. **Refer to "TO - Tobacco Use" on page 828**.

CF-TX TREATMENT

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

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing the available options.
2. Explain that management of cystic fibrosis varies from person to person depending on the organ systems which are involved.
3. Review the current treatment plan for this patient.
4. Discuss the importance of adhering to the treatment plan, including scheduled follow-up.

DVT - Deep Vein Thrombosis

OUTCOME: Patient/family will have an understanding of the potential complications of DVT.

STANDARDS:

1. Explain that the most common and important complication of DVT is pulmonary embolism, which can cause death.
2. Explain that the symptoms of a pulmonary embolism include shortness of breath, chest pain that may be worsened by deep breaths, and a cough that is productive and possibly flecked with blood.
3. Emphasize the importance of immediate medical intervention for signs and symptoms of pulmonary embolism.

DVT-DP DISEASE PROCESS

OUTCOME: Patient/family will have an understanding of what DVT is and factors that are associated with increased risk of DVT.

STANDARDS:

1. Explain that a DVT occurs when a blood clot partially or totally blocks the flow of blood in a deep vein. A DVT usually occurs in the leg, but may also occur in the arm or pelvis. This blood clot can result from injury to the vein or if the flow of blood slows down or stops.
2. Review the factors related to the development of DVT: age over 40, obesity, history of DVT, immobility, major injury, major surgery lasting over 30 minutes, surgery involving the leg joints or pelvis, cancer or some of its treatments, long-distance travel, pregnancy and childbirth, contraceptives or hormone replacement therapy, circulation problems, smoking, hereditary coagulation disorders.
3. Explain that the main signs and symptoms of DVT are leg pain that is worse when standing or walking, leg swelling, warmth and redness of the leg. Explain that only a physician, through test interpretation, is able to diagnose a DVT.

DVT-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of deep vein thrombosis.

STANDARDS:

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

3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up, e.g., shortness of breath, chest pain or pain, redness or swelling of the limb.
5. Discuss the availability of community resources and support services and refer as appropriate.

DVT-L LITERATURE

OUTCOME: The patient/family will receive literature about DVT.

STANDARDS:

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

DVT-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, duration, and expected outcomes of their drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, duration and storage of the medication. Anticoagulants do not dissolve the clot, but can stop new blood clots from forming and old ones from growing.
2. Discuss the risks, benefits and common or important side effects of the medication and follow up as appropriate.
   a. Discuss that some anticoagulants can cause birth defects. Emphasize the importance of contraception. Discuss the importance of consulting a physician if breastfeeding.
   b. Emphasize that the patient should avoid activities that could increase the risk of injury while taking anticoagulants.
3. Discuss any significant drug/drug or drug/food interactions, including interaction with alcohol. **Refer to "ACC - Anticoagulation" on page 74.**
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

DVT-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of DVT.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

DVT-N NUTRITION

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

STANDARDS:

1. Explain the importance of a consistent diet while receiving anticoagulation therapy.
2. Explain how various foods containing vitamin K may interact with the patient's medication to alter coagulation.
3. Explain how certain herbal therapies including large doses of vitamin E may alter the results of laboratory tests.
4. Refer to a registered dietitian for MNT as appropriate.

DVT-P PREVENTION

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

STANDARDS

1. Explain that surgery and some medical treatments can increase the risk of DVT.

2. Explain the role of anticoagulants, compression stockings and intermittent compression pumps in preventing DVT during hospitalization.
3. Explain general measures to prevent DVT:
    a. Exercise legs regularly.
    b. Maintain a healthy weight.
    c. Avoid sitting or lying in bed for long periods of time without moving the legs.
    d. Women, particularly those over 35, consider the risks and benefits of taking oral contraceptives or hormone replacement therapy.
    e. Tobacco use/exposure may increase the risk of DVT.
4. Explain general measures to prevent DVT while traveling:
    a. If one or more risk factors are present, seek medical advice before traveling.
    b. Exercise legs at least once every hour.
    c. As appropriate, take an aspirin before traveling four hours or more.
    d. Don't take sedatives.
    e. Wear loose-fitting, comfortable clothing.
    f. Keep legs uncrossed.
    g. Maintain hydration and avoid alcohol.
    h. Wear graduated compression stockings, as appropriate.

DVT-TE TESTS

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

STANDARDS:

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

DVT-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options that may be used to treat deep vein thrombosis.

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 adaptation, pharmacologic, surgical, and psychosocial aspects of the treatment plan.

D

DEH - Dehydration

DEH-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy/physiology of dehydration.

STANDARDS:

1. Explain that the human body is made of 70-80% water.
2. Explain that water from food and drink is absorbed through the small and large intestines.
3. Discuss that the kidneys regulate fluid status and under normal conditions initiate a thirst reflex. In some situations (vomiting, diarrhea, extreme heat, overexertion), the thirst reflex is not enough to replace fluid losses and dehydration may result.

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.
2. Discuss that milder dehydration may result in confusion, headache, dizziness, decreased urination. Explain that these symptoms should prompt a visit to a healthcare provider.

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, e.g., 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. Explain that these symptoms should prompt a visit to a healthcare provider.
5. Explain that consumption of caffeinated or heavily sugared beverages (such as cola or other soft drinks) may cause or contribute to dehydration and should not be substituted for water intake.
6. Discuss, as appropriate, that free water should be used with caution for infants under six months of age (may cause electrolyte abnormalities).
7. Discuss, as appropriate, 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 the types and the 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 follow-up in the treatment of dehydration.

STANDARDS:

1. Discuss the importance of follow-up care.

2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.

DEH-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of dehydration 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 for fluid and electrolyte replacement to decrease complications.

DEH-L LITERATURE

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

STANDARDS:

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

DEH- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for the treatment of dehydration.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.

3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

DEH-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition correcting or preventing dehydration.

STANDARDS:

1. Review the normal nutritional needs and daily fluid intake needed for optimal hydration.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits. Refer to a registered dietitian for MNT as appropriate.
3. Discuss nutritional modifications as related to dehydration.
4. Explain that excessive caffeine, alcohol, sugar beverages may lead to worsening dehydration.

DEH-P PREVENTION

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

STANDARDS:

1. Explain that taking/giving adequate water or oral electrolyte solutions (not caffeinated or alcoholic beverages) is essential to the prevention of dehydration, particularly in a hot/humid environment or during strenuous activity. This is especially important for babies, small children, pregnant women, and older adults.
2. Explain that clothing that contributes to excessive sweating may cause dehydration.
3. 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. Further tests 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.

DEH-TX TREATMENT

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 Treatment" on page 431**.
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 tooth anatomy and how it affects the susceptibility for decay.

STANDARDS:

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

DC-C COMPLICATIONS

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

STANDARDS:

1. Explain that when dental caries are treated, a portion of the healthy tooth structure must also be removed, resulting in a weakened tooth.
2. Explain that treatment may cause inflammation of the pulp. This may result in temporary soreness of the tooth, infection, and/or death of the tooth.
3. Explain that dental caries can cause abscess of the tooth, which may extend into a sinus or other adjacent tissues. Explain that some dental caries may involve so much of the tooth that root canal or removal of the tooth may be necessary.
4. Explain that early tooth loss in children may cause abnormal eruption of permanent teeth. Alternatively, explain that permanent tooth loss may result in loosening and loss of other permanent teeth.
5. Discuss the need for prophylactic antibiotics before dental work as indicated to prevent cardiac complications.

DC-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the causes of dental caries.

STANDARDS:

1. Explain that helpful and harmful bacteria live in the mouth, particularly in plaque.
2. Explain that carbohydrates cause bacteria to produce acids that weaken tooth structure (by dissolving and demineralizing). Progressive acid attacks on the tooth surface may lead to 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 (including sugar and soda). **Refer to "DC-N Nutrition" on page 309.**
   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 follow-up in the treatment of dental caries.

STANDARDS:

1. Discuss the importance of follow-up dental care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.

DC-HY HYGIENE

OUTCOME: The patient/family will recognize good oral hygiene as an aspect of wellness.

STANDARDS:

1. Discuss hygiene as part of a positive self image.
2. Review daily dental hygiene habits.
3. Discuss the importance of daily oral care in preventing cavities and gum disease.

DC-L LITERATURE

OUTCOME: The patient/family will receive literature about dental care.

STANDARDS:

1. Provide patient/family with literature on dental issues.
2. Discuss the content of the literature.

DC-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

DC-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of dental caries.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.

3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

DC-N NUTRITION

OUTCOME: The patient/family will understand the importance of good nutrition and its relationship to dental caries prevention.

STANDARDS:

1. Discuss the relationship between carbohydrates, and the development of dental caries. Give examples of foods high in simple sugars, e.g., soda, crackers, potato chips, candy, pre-sweetened cereals.
2. Explain that allowing a child to fall asleep with a bottle containing milk formula, fruit juices, or other sweet liquids may increase the risk of dental caries.
3. Discuss the importance of calcium and fluoride intake as it relates to tooth development and mineralization.
4. Refer to a registered dietician for MNT or other nutritional resource 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 Nutrition" on page 309**.
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.
6. Explain that the most common source of fluoride is unfiltered, fluoridated tap 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.

7. Explain that the use of topical fluoride is important in the prevention of decay in persons exposed to radiation therapy, as applicable.
8. As appropriate, discuss sealants as an intervention to prevent dental caries.
9. 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 - Periodontal Disease" on page 675.**
   c. Improper brushing methods.
   d. Genetic predisposition (frenulum/frenum attachment).

DC-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that pain management is specific to the disease process and patient. **Refer to "PM - Pain Management" on page 657.**
2. Explain that short-term use of acetaminophen, 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, e.g., avoid hot and cold foods.
5. Explain that local anesthetics and/or nitrous oxide may be used to control pain during dental procedures.

DC-PRO PROCEDURES

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

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. Explain that dental anxiety may be controlled or relieved by the use of anxiolytics or antihistamines as appropriate.

DC-TE TESTS

OUTCOME: The patient/family will understand the test to be performed, the risks/ benefits of the test and the risks of refusal.

STANDARDS:

1. Discuss the test to be performed and collection method, e.g., 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.
3. Explain the meaning of the test results.

DC-TO TOBACCO

OUTCOME: The patient/family will understand the role of tobacco use in dental caries.

STANDARDS:

1. Discuss that tobacco use is a significant risk factor for development of dental disease and tooth loss.
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. **Refer to "TO - Tobacco Use" on page 828**.

DC-TX TREATMENT

OUTCOME: The patient/family 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. Explain that dental anxiety may be controlled or relieved by the use of anxiolytics or antihistamines as appropriate.
3. Review the specific elements of oral care after treatment. **Refer to "DC-P Prevention" on page 309.**
4. Discuss the indications for immediate follow-up, e.g., continued bleeding, fever, persistent or increasing pain.

DEP - Depression, Major

DEP-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

DEP-DP DISEASE PROCESS

OUTCOME: The patient and/or family will understand the psychological and physiological causes of major depression.

STANDARDS:

1. Discuss the common symptoms of major depression with the patient and/or family:
   a. Persistent sadness lasting longer than two weeks
   b. Loss of interest in usual activities
   c. Weight loss or gain
   d. Sleep disturbances
   e. Energy loss
   f. Fatigue

g. Hyperactive or slowed behavior
h. Decreased or slowed sexual drive
i. Feelings of worthlessness
j. Difficulty concentrating or making decisions
k. Recurrent suicidal thoughts. **Refer to** **"SB - Suicidal Behavior" on page 808**.
l. Memory loss

2. Assure the patient and/or family that prognosis is usually good, with appropriate treatment.
3. Stress that many episodes of depression are not preventable. Treatment, including medications and psychiatric intervention, may prevent recurrences.
4. Discuss that antidepressant drug therapy combined with psychotherapy appears to have better results than either therapy alone.

DEP-EX EXERCISE

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

STANDARDS:

1. Explain that moderate exercise may increase energy, improve circulation, enhance sleep, and reduce stress and depression.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as the patient becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to** **"HPDP-EX Exercise" on page 480****.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

DEP-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the patient's responsibility in managing major depression.
2. Review the treatment plan with the patient/family, emphasizing the need for keeping appointments and adhering to medication regimens.
3. Instruct the patient/family to contact a mental health professional or other medical personnel if persistent thoughts of suicide occur.
4. Explain the process for making follow-up appointments.

DEP-IR INFORMATION AND REFERRAL

OUTCOME: The patient/family will receive information and referral for alternative or additional services as needed or desired.

STANDARDS:

1. Provide the patient/family with alternative or additional sources for care and services.
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

DEP-L LITERATURE

OUTCOME: The patient/family will receive literature about major depression.

STANDARDS:

1. Provide the patient/family with literature on major depression.
2. Discuss the content of the literature.

DEP-M MEDICATIONS

OUTCOME: The patient/family will understand the proper use of antidepressant medication.

STANDARDS:

1. Review the mechanism of action of the prescribed medication.

2. Discuss the proper use, the benefits, and the common side effects of prescribed medications.
3. Explain that some medications may have long-term effects that require regular monitoring and follow-up.
4. Discourage the use of alcohol and recreational drugs.
5. Explain that it may be six weeks before the antidepressant medication takes effect.
6. Explain that drug therapy may include one or a combination of tricyclic antidepressants, monoamine oxidase inhibitors, and serotonin re-take uptake blockers, or psychotropic medications that work by other mechanisms.
7. Discuss the risks associated with the medications especially in overdoseage. All medications should be stored in a safe place in child-resistant containers.
8. Discuss drug/drug and drug/food interactions as applicable.

DEP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

DEP-PSY PSYCHOTHERAPY

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

STANDARDS:

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

DEP-SCR SCREENING

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

STANDARDS:

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

DEP-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in major depression.

STANDARDS:

1. Explain that uncontrolled stress is linked with the onset of major depression and contributes to more severe symptoms of depression.
2. Explain that uncontrolled stress can interfere with the treatment of major depression.
3. Explain that effective stress management may reduce the severity of symptoms the patient experiences, as well as help improve the health and well-being of the patient.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the severity of the depression and increase risk of suicidal behaviors.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. Becoming aware of your own reactions to stress
    b. Recognizing and accepting your limits

c. Talking with people you trust about your worries or problems
d. Setting realistic goals
e. Getting enough sleep
f. Maintaining a reasonable diet
g. Exercising regularly
h. Taking vacations
i. Practicing meditation
j. Practicing self-hypnosis
k. Using positive imagery
l. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
m. Participating in spiritual or cultural activities

6. Provide referrals as appropriate.

DEP-WL WELLNESS

OUTCOME: The patient/family will understand some of the factors which contribute to a balanced and healthy lifestyle.

STANDARDS:

1. Explain that a healthy diet is an important component of emotional health.
2. Emphasize the importance of stress reduction and exercise in emotional health.
3. Refer the patient/family to support groups as appropriate.

DM - Diabetes Mellitus

DM-C COMPLICATIONS

OUTCOME: The patient/family will understand that serious complications may occur as a result of long-term uncontrolled blood glucose.

STANDARDS:

1. Emphasize that the end-organ damage (e.g., kidney failure, blindness, heart attack, impotence, limb amputations) results from long-term high blood glucose.
2. Emphasize that optimal blood glucose control can reduce the risk of complications and end-organ damage.
3. Explain that routine examinations are essential and monitoring for complications is required.
4. Discuss common complications of uncontrolled high blood glucose (e.g., blindness, impotence, increased yeast infections, increased urinary tract infections, kidney failure, loss of limbs, heart attack, stroke, early death).
5. Explain that patients with Type 2 DM are at high risk for infectious diseases. Review the current recommendations for immunizations and refer for immunization as appropriate. **Refer to "DM - Diabetes Mellitus" on page 318.**
6. Explain that patients with Type 2 DM are at high risk for visual loss. Review the current recommendations for eye examinations and refer to appropriate heath-care providers. **Refer to "ODM - Ocular Diabetes Mellitus" on page 628.**
7. Explain that uncontrolled blood glucose can result in small-vessel damage in the heart which leads to heart attacks and cannon usually be treated. Explain that Type 2 DM also worsens atherosclerotic disease, which can also lead to heart attacks and strokes. **Refer to "CVA - Cerebrovascular Disease" on page 159, "CAD - Coronary Artery Disease" on page 269,** and **"PVD - Peripheral Vascular Disease" on page 681.**

DM-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving optimal physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.

2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

DM-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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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.

DM-DP DISEASE PROCESS

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

STANDARDS:

1. Briefly describe the pathophysiology of Type 2 DM, including the concept of insulin resistance.
2. Emphasize that the end-organ damage (e.g., kidney failure, blindness, heart attack, impotence, limb amputations) results from high blood glucose and that the goal of management is to keep blood glucose as near to normal as possible.

3. Describe risk factors for development and progression of Type 2 DM, e.g., family history, obesity, high intake of simple carbohydrates, sedentary lifestyle.
4. Describe feelings/symptoms that the patient may experience when blood glucose is high, e.g., increased thirst, increased urination, lethargy, headache, blurry vision, impaired concentration.
5. Emphasize that Type 2 DM is a chronic, controllable condition which requires permanent lifestyle alterations and continuous attention and medical care. **Refer to "DM-LA Lifestyle Adaptations" on page 323.**

DM-EQ EQUIPMENT

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

STANDARDS:

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

DM-EX EXERCISE

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

STANDARDS:

1. Explain that increased daily 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 the patient becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to "HPDP-EX Exercise" on page 480.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

DM-FTC FOOT CARE AND EXAMINATIONS

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

STANDARDS:

1. Identify risks that can result in amputation. Stress that wounds do not heal properly if blood glucose is elevated.
2. Discuss the current recommendations for periodic foot screening.
3. Demonstrate the proper technique for a daily home foot check by patient or support person.
4. Discuss "do's and don'ts" of diabetic foot care (e.g., don't go barefoot, wear appropriate footwear, don't trim your own nails and/or ingrown toe nails, don't soak your feet).
5. Discuss the relationship between peripheral vascular disease, neuropathy, and high blood glucose. Explain that the progression to amputation is typical without early and appropriate intervention. **Refer to "PVD - Peripheral Vascular Disease" on page 681.**
6. Emphasize the importance of footwear which is properly fitted for patients with diabetes. Refer for professional evaluation and fitting as appropriate.
7. Remind the patient to remove shoes for each clinic visit.
8. Emphasize the importance of a regularly scheduled detailed foot exam by a trained healthcare provider.

DM-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of early intervention to prevent complications.
2. Explain that regular medical appointments are necessary to monitor and to adjust treatment plans to attain blood glucose, blood pressure, and lipid control.
3. Explain that the home glucose and home blood pressure monitoring logs are tools for evaluating the treatment plan and should be brought to every appointment.
4. Explain that diabetes management involves many healthcare providers. Explain that since Type 2 DM is a chronic condition which affects the entire body, total care is essential. Emphasize the importance of keeping appointments with all healthcare providers, e.g., dental, eye care, foot care, laboratory.
5. Discuss the procedure for making appointments.

DM-HM HOME MANAGEMENT

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

STANDARDS:

1. Discuss the specific components of this patient's home management (e.g., nutrition, exercise, home glucose monitoring, self-administration of insulin, taking medications).
2. Demonstrate and receive return demonstration of home glucose monitoring and/or insulin administration as appropriate.
3. Describe proper storage, care, and disposal of medicine and supplies.
4. Explain that home glucose monitoring (when prescribed) is a tool to assist the patient in home management of blood glucose.
5. Discuss the importance of logging home glucose readings and insulin administration and emphasize the importance of bringing the record to all medical appointments.
6. Emphasize the importance of daily foot checks and appropriate foot care. **Refer to "DM-FTC Foot Care And Examinations" on page 321.**

7. Emphasize the importance of good personal and oral hygiene. **Refer to "HPDP-HY Hygiene" on page 481**.
8. Emphasize the importance of nutritional management. Refer to registered dietician or other local resources as appropriate.

DM-KID KIDNEY DISEASE

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

STANDARDS:

1. Emphasize that high blood glucose results in damage to the kidneys. This may result in renal failure requiring long term dialysis or kidney transplant. Once kidney damage occurs it cannot be reversed.
2. Emphasize the need for regular urine analysis and blood chemistry screening.
3. Emphasize that high blood pressure worsens diabetic kidney disease. Reinforce the importance of regular blood pressure screening and taking antihypertensive medications as prescribed. **Refer to "HTN - Hypertension" on page 524.**

DM-L LITERATURE

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

STANDARDS:

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

DM-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

1. Emphasize that diet and exercise are the critical components of blood glucose control and medical therapies can at best supplement diet and exercise.
2. Emphasize that the end-organ damage (e.g., kidney failure, blindness, heart attack, impotence, limb amputations) results directly and indirectly from high blood

glucose and that the goal of management is to keep blood glucose as near to normal as possible.

3. Explain that the longer the blood glucose is elevated, the greater the damage will be.
4. State the reasons for blood glucose monitoring – to keep track of the level of blood glucose and permit changes to the treatment plan necessary to keep glucose under control.

DM-M MEDICATIONS

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

STANDARDS:

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

DM-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:

a. Assessment of the nutrition related condition.
b. Identification of the patient's nutritional problem.
c. Identification of a specific nutrition intervention therapy plan.
d. Evaluation of the patient's nutritional care outcomes.
e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

DM-N NUTRITION

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

STANDARDS:

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

DM-ODM OCULAR DIABETES MELLITUS (RETINOPATHY)

OUTCOME: The patient and family will understand that uncontrolled diabetes mellitus can result in eye damage or blindness.

STANDARDS:

1. Explain that retinopathy is the leading cause of blindness in adults.

2. Discuss the importance of maintaining glycemic control to prevent retinopathy.
3. Discuss the relationship between peripheral vascular disease, retinopathy, and high blood glucose.
4. Discuss the current recommendations for annual retinal examination, and make appropriate referral.
5. **Refer to "ODM - Ocular Diabetes Mellitus" on page 628.**

DM-P PREVENTION

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

STANDARDS:

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

DM-PD PERIODONTAL DISEASE

OUTCOME: The patient/family will understand the risk of uncontrolled diabetes mellitus as it relates to dental health.

STANDARDS:

1. Explain that gum disease can contribute to poor glycemic control.
2. Explain that gum disease can contribute to poor glycemic control.
3. Explain that the mouth (gums) contain highly vascular surface tissues that are easily damaged by poor glycemic control.
4. Explain that damage to gum tissues can result in loss of teeth and bone mass.
5. Discuss the current recommendation for annual dental examination and make appropriate referral.

6. **Refer to "PD - Periodontal Disease" on page 675.**

DM-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that lower extremity pain may be significant for complications associated with neuropathy which needs to be discussed with the medical provider.
2. Explain that the use of over the counter medications for chronic pain management needs to be assessed by the medical provider to minimize risk to kidney function.
3. Explain that all chest pain must be evaluated by the medical provider to rule out the possibility of myocardial infarction.
4. **Refer to "PM - Pain Management" on page 657 or "CPM - Chronic Pain" on page 249.**

DM-SCR SCREENING

OUTCOME: The patient/family will understand the proposed screening test including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed screening test (e.g., guaiac, blood pressure, hearing, vision, development, mental health).
2. Explain the process and what to expect after the test.
3. Emphasize the importance of follow-up care.
4. Explain the recommended frequency of various screenings.

DM-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in diabetes mellitus.

STANDARDS:

1. Explain that uncontrolled stress can contribute to insulin resistance and lead to increased morbidity and mortality.
2. Explain that uncontrolled stress can interfere with the treatment of diabetes mellitus.

3. Explain that effective stress management may reduce the adverse consequences of diabetes, 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 diabetes mellitus.
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. Practicing self-hypnosis
   k. Using positive imagery
   l. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   m. Participating in spiritual or cultural activities
6. Provide referrals as appropriate.

DM-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, e.g., 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.

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

DIA - Dialysis

DIA-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

DIA-C COMPLICATIONS

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

STANDARDS:

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

DIA-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving optimal physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

DIA-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the causes associated with the patient's end stage renal disease.

STANDARDS:

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

DIA-EQ EQUIPMENT

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

STANDARDS:

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

DIA-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand the importance of fully participating in the treatment regimen and appropriate follow-up and coordination with all healthcare providers.

STANDARDS:

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

DIA-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

DIA-M MEDICATION

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

STANDARDS:

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

DIA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

DIA-N NUTRITION

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

STANDARDS:

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

DIA-PRO PROCEDURES

OUTCOME: The patient/family will 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).

DIA-TE TESTS

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

STANDARDS:

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

DCH - Discharge from Hospital

DCH-EQ EQUIPMENT

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

STANDARDS:

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

DCH-FU FOLLOW-UP

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

STANDARDS:

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

DCH-HM HOME MANAGEMENT

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

DCH-L LITERATURE

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

STANDARDS:

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

DCH-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

DCH-M MEDICATIONS

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

STANDARDS:

1. Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.

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

DCH-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

DCH-N NUTRITION

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

STANDARDS:

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

DCH-POC PLAN OF CARE

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

STANDARDS:

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

DCH-PRO PROCEDURES

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

STANDARDS:

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

DCH-REF REFERRAL

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

STANDARDS:

1. Choose from the following standards as appropriate.
   a. Emphasize that referrals to outside providers by Indian Health Service primary providers typically will be processed by Contract Health Services.

b. Explain the procedure for the referral to the private sector is usually based on a priority system and/or waiting list.

c. Explain that coverage by insurance companies and Medicare/Medicaid packages will be utilized prior to utilizing contract health service funds in most cases. The Indian Health Service is a payer of last resort.

d. Discuss the rules/regulations of Contract Health Services.

e. Refer as appropriate to community resources for Medicaid/Medicare enrollment, e.g., Benefits Coordinator.

f. Discuss the importance of follow-up care and the requirement to notify contract health services of any future appointments and procedures by the private sector. **Referrals are for one visit only** (unless otherwise specified.) Future and/or additional referrals must be approved prior to the appointment.

DCH-RI PATIENT RIGHTS AND RESPONSIBILITIES

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

STANDARDS:

1. Discuss the patient's responsibility to follow the agreed upon plan of care and to keep follow-up appointments.
2. Briefly explain the process for resolving conflicts if the patient/family believe that their rights have been violated.
3. Discuss availability of cultural/spiritual/psycho social services that may be available as appropriate.

DCH-S SAFETY

OUTCOME: The patient/family will understand the necessary precautions to prevent injury following hospital discharge.

STANDARDS:

1. Discuss the mutually agreed upon plan of care for safety based on the patient-specific risk assessment.
2. Emphasize safe use of equipment. **Refer to "DCH-EQ Equipment" on page 335.**

DCH-TE TESTS

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

STANDARDS:

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

DCH-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, cultural practices, pharmacologic, and psycho social aspects of the treatment plan.
3. Discuss the importance of participating in the treatment plan, including scheduled follow-up.
4. Refer to community resources as appropriate.

DIV - Diverticulitis / Diverticulosis

DIV-C COMPLICATIONS

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

STANDARDS:

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

DIV-DP DISEASE PROCESS

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

STANDARDS:

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

DIV-FU FOLLOW-UP

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

STANDARDS:

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

DIV-L LITERATURE

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

STANDARDS:

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

DIV-M MEDICATIONS

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

STANDARDS:

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

DIV-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.

b. Identification of the patient's nutritional problem.
c. Specific nutrition intervention therapy plan.
d. Evaluation of the patient's nutritional care outcomes.
e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

DIV-N NUTRITION

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

STANDARDS:

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

DIV-P PREVENTION

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

STANDARDS:

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

DIV-PM PAIN MANAGEMENT

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

STANDARDS:

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

DIV-TE TESTS

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

STANDARDS:

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

b. Explain that barium liquid will be introduced by enema and radiographs taken.

c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.

DIV-TX TREATMENT

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

STANDARDS:

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

DV - Domestic Violence

DV-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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 will 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-IR INFORMATION AND REFERRAL

OUTCOME: The patient/family will receive information and referral for alternative or additional services as needed or desired.

STANDARDS:

1. Provide the patient/family with alternative or additional sources for care and services.
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

DV-L LITERATURE

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

STANDARDS:

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

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 Disease Process" on page 346**.
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

OUTCOME: 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. Practicing self-hypnosis
   k. Using positive imagery
   l. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   m. Participating in 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 the patient and the family need to acknowledge, admit, and request help.
3. Review the 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, e.g., 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, e.g., 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, e.g., 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, e.g., 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-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Discuss anatomy/physiology as it applies to early childhood caries.
2. Discuss pathophysiology of ECC.
3. Explain that it is possible for tooth decay to begin even before tooth eruption.

ECC-C COMPLICATIONS

OUTCOME: The parent/family will understand the effects and consequences of ECC.

STANDARDS:

1. Review the consequences of severe tooth decay, e.g., infection, tooth loss, speech problems, aesthetics.
2. Review treatment modalities (tooth restoration, behavior management).
3. Review the health risks of general anesthesia.
4. Explain that early tooth loss in children may cause abnormal eruption of permanent teeth.

ECC-DP DISEASE PROCESS

OUTCOME: The parent/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 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 patient/family will understand the importance of follow-up in the treatment of early childhood caries.

STANDARDS:

1. Discuss dental well child visits and the importance of follow up.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss the indications for immediate follow up, e.g., bleeding, persistent or increasing pain, and fever.
5. Discuss the availability of community resources and support services and refer as appropriate.

ECC-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent/family will understand primary dentition.

STANDARDS:

1. Explain how dentition begins during fetal development. 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 LITERATURE

OUTCOME: The parent/family will receive literature about ECC.

STANDARDS:

1. Provide parent/family with literature on ECC.
2. Discuss the content of the literature.

ECC-LA LIFESTYLE ADAPTATIONS

OUTCOME: The parent/family will understand positive oral hygiene habits.

STANDARDS:

1. Review breastfeeding, bottle feeding practices, and oral hygiene.

2. Provide information on alternatives to misuse of baby bottles, e.g., no bottles in the bed, no propping of bottles, weaning at 12 months of age.

ECC-M MEDICATIONS

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

STANDARDS:

1. Describe the proper use, benefits, and common or important side effects of the medication.
2. Discuss any significant drug/drug or drug/food interactions.
3. Discuss the importance of keeping a list of current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements to keep your doctor informed.

ECC-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The parent/family will understand the specific nutritional intervention(s) needed for treatment or management of early childhood caries.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the parent/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ECC-N NUTRITION

OUTCOME: The parent/family will understand the role of nutrition and early childhood caries.

STANDARDS:

1. Review normal nutritional needs for optimal 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. Explain that allowing a child to fall asleep with a bottle containing milk formal, fruit juices, or other sweet liquids may increase the risk for dental caries.

ECC-P PREVENTION

OUTCOME: The parent/family will understand how to prevent ECC with healthy lifestyle behaviors.

STANDARDS:

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

ECC-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that pain management as it relates to ECC. **Refer to "PM - Pain Management" on page 657**.
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, e.g., avoid hot and cold foods.

ECC-PRO PROCEDURES

OUTCOME: The parent/family will understand procedures to be performed to treat ECC and the risk of not treating ECC.

STANDARDS:

1. Discuss the process, indications, risks, and benefits for the proposed procedure.
2. Discuss pain management and anxiolytics as appropriate.
3. Emphasize post-procedure management and follow-up. Instruct to return to the provider for bleeding, persistent or increasing pain and fever.

ECC-TE TESTS

OUTCOME: The parent/family will understand the test to be performed, the risks/ benefits of the test and the risks of refusal of the test.

STANDARDS:

1. Discuss the test to be performed and collection method, e.g., x-ray.
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment and the risks of refusal.
3. Explain the meaning of test results.

ECC-TX TREATMENT

OUTCOME: The parent/family will understand the necessary treatment.

STANDARDS:

1. Explain the basic procedure to be used (e.g., filling, capping) and the indication, common complications, alternatives, and the risks of non-treatment.
2. Review the specific elements of oral care after treatment. **Refer to "DC - Dental Caries" on page 306 and "ECC-P Prevention" on page 358.**
3. Discuss the indications for returning to the provider, e.g., 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, e.g., 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, e.g., pain, swelling, redness, drainage, or a fever. **Refer to "SWI - Skin and Wound Infections" on page 796**.
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 LITERATURE

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

STANDARDS:

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

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-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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, e.g., 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, e.g., 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.

ELD - Elder Care

ELD-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family/caregiver will understand the process of developing an advance directive and its role in maintaining a sense of control in the patient's medical care and decisions.

STANDARDS:

1. Explain that patients may lose the ability to make their own decisions and an advance directive will be able to express the patient's desires prior to the loss of decision-making abilities.
2. Review the option of Advanced Directives/Living Will with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
3. Refer to appropriate services to assist the patient in making a living will, e.g., Social Services, Clergy, Lawyer.
4. **Refer to "ADV - Advance Directives" on page 40.**

ELD-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33.**

ELD-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family/caregiver 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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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.

ELD-DP DISEASE PROCESS/AGING

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

STANDARDS:

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

ELD-EQ EQUIPMENT

OUTCOME: The patient/family/caregiver will understand 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 the types and the features of the medical equipment as appropriate.
3. Discuss and/or demonstrate the proper use, care, cleaning, and safety implications 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.

ELD-EX EXERCISE

OUTCOME: The patient/family/caregiver 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. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Discuss obstacles to a personal exercise plan and solutions to those obstacles. Assist the patient in developing a personal exercise plan.
4. Encourage the patient to increase the intensity and duration of the activity as the patient becomes more fit.
5. Refer to community resources as appropriate.

ELD-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand the importance of follow-up in elder care.

STANDARDS:

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

ELD-HY HYGIENE

OUTCOME: The patient/family/caregiver 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. Explain that elders are at increased risk of communicable diseases.

ELD-L LITERATURE

OUTCOME: The patient/family/caregiver will receive literature about aging or elder healthcare issues.

STANDARDS:

1. Provide the patient/family/caregiver with literature on aging or elder healthcare issues.
2. Discuss the content of the literature.

ELD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family/caregiver will understand the lifestyle adjustments needed to maintain optimal health and will develop a plan to modify behavior where needed.

STANDARDS:

1. Discuss the patient/family/caregiver level of understanding and acceptance of the aging process.
2. Review the lifestyle areas that may require adaptations, e.g., diet, physical activity, sexual activity, bladder/bowel function, role changes, communication skills, interpersonal relationships, transportation issues, isolation issues, safety and injury prevention.
3. Explain that as people age they may require more assistance from other sources than previously. Assist in identifying a support system.
4. Refer to Social Services, Mental Health, Physical Therapy, Rehabilitative Services, and/or other resources, as appropriate.

ELD-M MEDICATIONS

OUTCOME: The patient/family/caregiver will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

ELD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family/caregiver will understand the specific nutritional intervention(s) needed for the elderly.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family/caregiver in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ELD-N NUTRITION

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

STANDARDS:

1. Review the patient's nutritional needs for optimal health.
2. Identify problems, such as dental or gum disease, financial limitations, cognitive limitations, or other conditions that may limit the patient's ability to achieve good nutrition.
3. Emphasize the necessary component – WATER – in a healthy diet. Reduce the use of colas, coffee and alcohol.
4. Encourage participation in Meals-on-Wheels, food stamps, or congregate feeding programs as appropriate.
5. Refer to a registered dietician for MNT as appropriate.

ELD-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

1. Explain the importance of body mechanics in daily living to avoid injury, e.g., proper lifting techniques.

2. Assist the patient/family/caregiver in identifying ways to adapt the home to improve safety and prevention injuries, e.g., remove throw rugs, install bars in tub/ shower, secure electrical cords, install ramps.
3. As appropriate, stress the importance of mobility assistance devices, e.g., canes, walkers, wheel chairs, therapeutic shoes.
4. Discuss the current/potential abuse of alcohol or drugs.
5. Emphasize the importance of NEVER smoking in bed. Refer to smoking cessation programs as appropriate. **Refer to "TO - Tobacco Use" on page 828.**
6. Discuss the potential for elder abuse/neglect (including financial exploitation) and ways to identify abuse/neglect. Refer as appropriate.

ELD-SM STRESS MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the role of stress management when taking care of the elderly.

STANDARDS:

1. Explain that uncontrolled stress can contribute to physical illness, emotional distress, and early mortality of the caregiver.
2. Emphasize the importance of seeking professional help as needed to reduce stress.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality of both the caregiver and the elder.
4. Explain that effective stress management may help to improve the health and well-being.
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 healthy diet
   g. Exercising regularly
   h. Taking vacations
   i. Practicing meditation, self-hypnosis, and positive imagery

j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation

k. Participating in spiritual or cultural activities

6. Provide referrals as appropriate, e.g., respite care, behavioral or mental health.

ELD-WL WELLNESS

OUTCOME: The patient/family/caregiver will understand ways to promote optimal health and wellness.

STANDARDS:

1. Explain the importance of regular healthcare visits and screening exams, e g., colonoscopy, mammograms, PSA, pap smears.
2. Discuss proper hydration, nutrition, exercise, and stress management as components of wellness.

EOL - End of Life

EOL-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

EOL-DP DISEASE PROCESS

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

STANDARDS:

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

EOL-EQ EQUIPMENT

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

STANDARDS:

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

EOL-GP GRIEVING PROCESS

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

STANDARDS:

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

EOL-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

1. Provide patient/family with written patient information literature.

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

EOL-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

EOL-LW LIVING WILL

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

STANDARDS:

1. Review the option of Advanced Directives/ Living Will with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
2. Refer to appropriate services to assist the patient in making a living will, e.g., Social Services, Clergy, Lawyer.

3. Discuss giving designated persons access to the patient's complete health record and care management, including all necessary legal documents.

EOL-M MEDICATIONS

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

STANDARDS:

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

EOL-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

EOL-N NUTRITION

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

STANDARDS:

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

EOL-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that pain management is specific to the disease process/aging process of this particular diagnosis and patient; and may be multifaceted. **Refer to "PM - Pain Management" on page 657.**
2. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain.
3. Explain non-pharmacologic measures that may be helpful with pain control.

EOL-PSY PSYCHOTHERAPY

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

STANDARDS:

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

EOL-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress can contribute to a faster decline in physical health and cause further emotional distress for the patient, as well as contribute to physical illness, emotional distress, and early mortality of the caregiver.

2. Explain that effective stress management may help to improve the patient's outlook, as well as the health and well-being of both the patient, caregiver and family members.
3. Emphasize the importance of seeking professional help as needed to reduce stress.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality of both the caregiver and the patient.
5. Discuss various stress management strategies which may maintain or improve quality of life. Examples for patient, caregiver and family members may include:
   a. Becoming aware of your own reactions to stress
   b. Recognizing and accepting your limits
   c. Talking with people you trust about your worries or problems
   d. Setting realistic goals
   e. Getting enough sleep
   f. Maintaining a reasonable diet
   g. Exercising regularly
   h. Practicing meditation
   i. Practicing self-hypnosis
   j. Using positive imagery
   k. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   l. Participating in spiritual or cultural activities
6. Provide referrals as appropriate.

EOL-TX TREATMENT

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

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of a treatment plan.
2. Explain what signs/symptoms should prompt an immediate call to the provider.
3. Explain the difference between palliative and curative treatments.

4. Explain that end of life treatments will typically not prolong the patient's life but are meant to improve the quality of life by increasing patient comfort.

EYE - Eye Conditions

EYE-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

EYE-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications of their ocular condition.

STANDARDS:

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

EYE-DP DISEASE PROCESS

OUTCOME: The patient/family will understand their ocular condition.

STANDARDS:

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

EYE-FU FOLLOW-UP

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

STANDARDS:

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

3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

EYE-HM HOME MANAGEMENT

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

STANDARDS:

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

EYE-L LITERATURE

OUTCOME: The patient/family will receive literature about eye conditions.

STANDARDS:

1. Give the patient/family literature about eye conditions.
2. Discuss the content of the information.

EYE-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

EYE-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

EYE-P PREVENTION

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

STANDARDS:

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

EYE-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to "PM - Pain Management" on page 657.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.

3. Discuss non-pharmacologic measures that may be helpful with pain control, e.g., warm or cool packs.

EYE-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.

EYE-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered and method of collection.
2. Explain the necessity, benefits, and risks of test(s) to be performed. Explain any potential risk of refusal of recommended test(s).
3. Inform patient of any advance preparation and instructions for the test(s).
4. Explain that follow-up tests may be ordered based on the results.

EYE-TX TREATMENT

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

STANDARDS:

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

F

FALL - Fall Prevention

FALL-C COMPLICATIONS

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

STANDARDS:

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

FALL-DP DISEASE PROCESS

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

STANDARDS:

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

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

FALL-FU FOLLOW-UP

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

STANDARDS:

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

FALL-L LITERATURE

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

STANDARDS:

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

FALL-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

1. Explain that wearing non-skid slippers when out of bed may prevent slipping and falling.
2. In the home or in the hospital, stress the importance of calling for help or using the call light or other call devices to call for assistance if dizziness and/or weakness are experienced.

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

FALL-SCR SCREENING

OUTCOME: Patient/Family will have an understanding of the screening process for implementing interventions to decrease the risk of falls.

STANDARDS:

1. Explain that screening for fall risk allows for implementation of appropriate interventions.
2. Explain that factors associated with an increased risk of falls are assessed at intervals prescribed by hospital policy if the patient is hospitalized.
3. Discuss that screening may include mobility, mentation, medication effects, issues with elimination, and history of falls.

FP - Family Planning

FP-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

FP-DIA DIAPHRAGM

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

STANDARDS:

1. Discuss the method of insertion. Emphasize the use of spermicide. Discuss the amount of time the diaphragm must be left in place.
2. Emphasize that the diaphragm must be used each time intercourse takes place.
3. Emphasize that the diaphragm must be refitted if there is a 10 pound weight loss or gain, and after childbirth.
4. Explain that a diaphragm can prevent pregnancy, if used correctly, but does not reduce the risk of sexually transmitted infections.

FP-DPO DEPOT MEDROXYPROGESTERONE INJECTIONS

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

STANDARDS:

1. Explain the method of action and effectiveness of depot medroxyprogesterone. Discuss the method of administration and importance of receiving the medication as recommended (typically every 3 months).
2. Discuss the contraindications, risks, and side effects of the medication, including long term bone health and menstrual cycle disturbances.
3. Explain the need for follow up if pregnancy is suspected.
4. Explain that depot medroxyprogesterone can prevent pregnancy, if used correctly, but does not reduce the risk of sexually transmitted infections.

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, such as, 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. Emphasize the importance of use each time intercourse takes place.
2. Explain why condoms must be applied before penetration. Emphasize that the male must withdraw before erection subsides.

3. Advise concomitant use of spermicidal foam as recommended by the medical provider.
4. Discuss use of spermicidal suppositories and intravaginal films.
5. Discuss that condoms may possibly provide protection against STIs when properly used.
6. Discuss and demonstrate, where appropriate, the proper application, storage, and disposal.

FP-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

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. Explain that implantable contraceptives can prevent pregnancy if used correctly, but do not reduce the risk of sexually transmitted infections
5. Stress the importance of yearly follow-up.

FP-IR INFORMATION AND REFERRAL

OUTCOME: The patient/family will receive information and referral for alternative or additional services as needed or desired.

STANDARDS:

1. Provide the patient/family with alternative or additional sources for care and services.
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.
3. Offer behavioral health follow-up as appropriate.

FP-IUD INTRAUTERINE DEVICE

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

STANDARDS:

1. Explain how IUDs work and that IUDs are more easily retained in multiparous vs. nulliparous women.
2. Emphasize the importance of monthly string checks.
3. Emphasize the importance of reporting abnormal vaginal discharge, fever, or pain with intercourse.
4. Discuss contraindications to placement of IUDs.
5. Explain that the IUD can prevent pregnancy, if used correctly, but does not reduce the risk of sexually transmitted infections
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 LITERATURE

OUTCOME: The patient/family will receive literature about family planning.

STANDARDS:

1. Provide parent/family with literature on family planning.
2. Discuss the content of the literature.

FP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for family planning.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of the specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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 and how each method is used in preventing pregnancy.
2. 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. Discuss the amount of folic acid required. Identify supplemental forms of folic acid. Examples foods rich in folic acid are pinto and navy beans, cold cereals, asparagus, raw spinach, romaine lettuce, broccoli, instant breakfast, etc.
2. Explain that to be maximally effective, folic acid should be given before conception.

3. Discuss the importance of a balanced diet. Refer to a registered dietitian for MNT as appropriate.

FP-OC ORAL CONTRACEPTIVES

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

STANDARDS:

1. Discuss the medication name, the dosing instructions, actions, and the common side effects of prescribed oral contraceptives.
2. Discuss how to handle missed or delayed doses of oral contraceptives.
3. Discuss when condoms/barrier methods should be used as an additional precaution (initiation, obesity, missed doses, or drug/herbal interactions e.g., antibiotics, anti-epileptics, or other medications that reduce the effectiveness of the oral contraceptives).
4. Discuss the contraindications, risks, and signs/symptoms of complications.
5. Explain that oral contraceptives can prevent pregnancy if used correctly, but do not reduce the risk of sexually transmitted infections.
6. Explain the need for follow up if pregnancy is suspected or other menstrual cycle disturbances occur.

FP-ST STERILIZATION

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

STANDARDS:

1. Explain the risks and benefits of sterilization methods (e.g., bilateral tubal ligation, bilateral vasectomy), emphasizing that these are PERMANENT methods of contraception.
2. Review availability of other methods that can prevent or delay pregnancy as an option to permanent sterilization.
3. Explain the surgical procedure, including anesthesia (local or general), for the type of sterilization.
4. Discuss the possible side effects and risks: infection, pain, hemorrhage, and failure rate.

5. Explain that IHS and the state may have specific legal criteria that must be met in order to be eligible for sterilization. IHS does not authorize the reversals of permanent procedures.
6. Explain that sterilization can prevent pregnancy, but does not reduce the risk of sexually transmitted infections.

FP-TD TRANSDERMAL (PATCH)

OUTCOME: The patient/family will understand the safe and effective use of transdermal contraception.

STANDARDS:

1. Discuss actions, benefits, and common side effects of transdermal contraception.
2. Discuss where the patch may be applied and the schedule of changing the patch and how to handle missed, delayed, or misplaced patches.
3. Discuss when condom/barriers should be used as an additional precaution (initiation, obesity, missed doses, or drug/herbal interactions e.g., antibiotics, anti-epileptics, or other medications that reduce the effectiveness of the patch).
4. Discuss the contraindications, risks, and signs/symptoms of complications.
5. Explain the need for follow up if pregnancy is suspected or other menstrual cycle disturbances occur.
6. Explain that transdermal contraception can prevent pregnancy, if used correctly, but does not reduce the risk of sexually transmitted infections.

FP-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered and method of collection.
2. Explain the necessity, benefits, and risks of test(s) to be performed. Explain any potential risk of refusal of recommended test(s).
3. Inform patient of any advance preparation and instructions required for the test(s).

FAS - Fetal Alcohol Syndrome

FAS-ADL ACTIVITIES OF DAILY LIVING

OUTCOME: The patient/family/caregiver will understand how the patient's ability to perform activities of daily living (ADLs) impact the care plan including in-home and out-of-home care.

STANDARDS:

1. Define activities of daily living (ADLs) (e.g., the everyday activities involved in personal care such as feeding, dressing, bathing, movement, toileting and walking) and discuss how the patient's ability to perform ADLs affects their ability to live independently.
2. Provide the appropriate information and referrals for services needed to increase, maintain, and/or assist with activities of daily living.

FAS-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving optimal physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

FAS-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the nature of FAS and FASD (Fetal Alcohol Spectrum Disorder), and that the consequences can be manifested as a life long disability.

STANDARDS:

1. Discuss that consumption of any amount of alcohol during pregnancy can cause FAS.

2. Explain that FAS and FASD are a cluster of physical, mental, and neurodevelopmental birth defects that occur as a result of prenatal exposure to alcohol. These birth defects are life long, and may include:
    a. Behavioral problems
    b. Learning and memory problems
    c. Impaired cognition and mental retardation
    d. Language and communication problems
    e. Visual-spatial impairment
    f. Executive functioning problems (e.g., planning, sequencing, organizing, abstract thinking)
    g. Attention/concentration difficulties
    h. Motor control problems (e.g., coordination, balance, gait, muscle tone/control)
    i. Sensory integration difficulties
    j. Challenges living independently

FAS-GD GROWTH AND DEVELOPMENT

OUTCOME: The patient/family/caregiver will have an increased understanding of the factors that contribute to growth and development for children, adolescents, and adults with FAS/FASD.

STANDARDS:

1. Discuss the role of pre and postnatal factors for the growth and development for individuals affected by prenatal alcohol exposure.

FAS-IR INFORMATION AND REFERRAL

OUTCOME: The patient/family/caregiver will receive information and referral for alternative or additional services as needed or desired.

STANDARDS:

1. Provide the patient/family/caregiver with alternative or additional sources for care and services.
2. Provide the patient/family/caregiver with assistance in securing alternative or additional resources as needed.

FAS-L LITERATURE

OUTCOME: The patient or caregiver will receive literature about FAS/FASD.

STANDARDS:

1. Provide patient or caregivers with literature on FAS/FASD.
2. Discuss the content of the literature.

FAS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/caregiver will have an increased understanding of the factors that contribute to better outcomes for children, adolescent, and adults with FAS/FASD.

STANDARDS:

1. Review the lifestyle areas that may require adaptations (e.g., home, school, job, physical activity, recreational/leisure activity, communication, and social skills, etc.). Discuss that effective intervention for individuals with FAS/FASD often requires restructuring the home, community, and school environments.
2. Explain that the interventions for FAS/FASD require on-going family/caregiver involvement.
3. Explain that the 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 consistent, simple, direct, and concrete communication.
6. Discuss the effects of parent stress and marital problems on children and adolescents.
7. Discuss that behavioral and developmental problems associated with FAS/FASD may exacerbate parental stress and marital problems. Explain that appropriate help should be sought as soon as the problem is identified.
8. Refer to Social Services, Behavioral Health, Physical Therapy, Speech Therapy, or other rehabilitative services and/or community resources as appropriate.

FAS-PN PRENATAL

OUTCOME: The patient/family will understand the consequences of alcohol use during pregnancy.

STANDARDS:

1. Discuss that consumption of any amount of alcohol during pregnancy can cause FAS or FASD.
2. Emphasize the importance of abstinence from any alcohol use during pregnancy (including beer, wine, liquor, and wine coolers).
3. Discuss available treatment or intervention options, as appropriate.

FAS-TE TESTS

OUTCOME: The patient/family/caregiver will understand the importance of diagnosis and the testing process to be performed to diagnose FAS/FASD.

STANDARDS:

1. Discuss the benefits of seeking a diagnostic evaluation for FAS/FASD.
2. Answer the patient/family questions regarding the evaluation process.
3. Refer to appropriate FAS Diagnostic resources within the healthcare system or community, 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 - Neonatal Fever" on page 608.**

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, e.g., 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 the proper use, the care, and the 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 (e.g., 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 - Neonatal Fever" on page 608**.

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. Because 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 LITERATURE

OUTCOME: The patient/family will receive literature about fever.

STANDARDS:

1. Provide the patient/family with literature on fever.
2. Discuss the content of the literature.
3. Explain the need for follow-up if the fever lasts for more than three 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 (e.g., 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, e.g., 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.

FMS - Fibromyalgia Syndrome

FMS-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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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.

FMS-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of fibromyalgia.

STANDARDS:

1. Review fibromyalgia (FMS) as a collection of complex symptoms characterized by achy pain and stiffness in soft muscle tissues, including muscles, tendons, and ligaments. The pain and stiffness of FMS may be widespread throughout the body or localized, especially along the spine.
2. Explain that there is currently no reliable laboratory test available to make the diagnosis of FMS and that the examining physician must rely on a patient's medical history and physical findings of tender points on examination.
3. Discuss the patient's specific conditions, including anatomy and physiology as appropriate.

4. Explain that FMS is disruptive, but not life threatening. Women are more likely to have fibromyalgia.
5. Symptoms may include sleep disturbance, depression, fatigue, headaches, diarrhea and/or constipation, numbness in hands and feet, weakness, memory changes, and dizziness.
6. Review lifestyle factors that may worsen or aggravate the symptoms (e.g., overweight, obesity, sedentary lifestyle, higher levels of emotional stress, and ineffective coping skills)

FMS-EX EXERCISE

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

STANDARDS:

1. Explain that regular aerobic activity will reduce the symptoms of fibromyalgia.
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 the patient becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to "HPDP-EX Exercise" on page 480.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

FMS-FU FOLLOW-UP

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

STANDARDS:

1. Provide positive reinforcement for areas of achievement.
2. Emphasize the importance of follow-up care to prevent complications and adjustments of medications.
3. Encourage active participation in the treatment plan.

4. Explain the procedure for obtaining appointments.

FMS-L LITERATURE

OUTCOME: The patient/family will receive literature about FMS.

STANDARDS:

1. Provide patient/family with literature on FMS.
2. Discuss the content of the literature.
3. Point out to the patient/family the numerous professional organizations that are knowledgeable about FMS pain management.

FMS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand what lifestyle adaptations are necessary to cope with FMS.

STANDARDS:

1. Explain that the patient has a responsibility to make lifestyle adaptations in controlling pain. It is a process of making wise choices and changes that will positively affect the overall state of health.
2. Emphasize the importance of rest and the avoidance of fatigue.
3. Discuss the use of heat and cold as appropriate.
4. Refer to Social Services, Behavioral Health, Physical Therapy, Registered Dietician, Rehabilitative Services, and/or community resources, as appropriate.
5. Review the areas that may require adaptations: diet, physical activity, sexual activity, and bladder/bowel habits.

FMS-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication(s) FMS.

STANDARDS:

1. Review the patient's medication. Reinforce the importance of knowing the medication, dose, and dosing interval of medications.
2. Discuss potentially adverse interactions with other drugs (e.g., OTC medications, traditional/herbal medications) and the adverse effects of this medication when combined with certain foods.

3. Emphasize the importance of checking with a medical provider prior to starting any prescription, OTC, or herbal/traditional treatments.
4. Discuss the importance of taking medications as prescribed. It is important not to increase the dose of medications without first consulting the healthcare provider.

FMS-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

FMS-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand pain management techniques.

STANDARDS

1. Discuss non-pharmacologic pain control measures such as:
   a. Learning techniques that relieve stress and promote relaxation.
   b. Practicing good health habits such as eating a nutritious diet, managing weight, and getting adequate sleep, and avoiding alcohol, highly sugared foods, caffeine drinks, and tobacco.
   c. Understanding the feeling that pain creates.
   d. Becoming more physically active.
   e. Organizing the day and performing daily tasks more efficiently.
   f. Identifying capabilities and not just limitations.

g. Improving communications with family and friends.

h. Practicing weight loss, if overweight.

i. Addressing any problems with sleep disturbances.

j. Exploring alternative/complimentary medicine such as massage, acupuncture, chiropractic, yoga, and Tai Chi, traditional healing, and hypnosis.

FMS-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress may exacerbate the symptoms of the chronic pain of FMS. This can set up a cycle of pain-stress which becomes self-sustaining and may escalate.
2. Explain that uncontrolled stress can interfere with the treatment of chronic pain.
3. Discuss that in chronic pain, uncontrolled stress may lead to depression or other mood disorders. **Refer to "CPM-PSY Psychotherapy" on page 253**.
4. Explain that effective stress management may reduce the severity of symptoms the patient experiences, as well as, help improve the health and well-being of the patient.
5. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol, or other substance use as well as overeating, all which can increase the severity of pain.
6. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
   a. Becoming aware of your own reactions to stress
   b. Recognizing and accepting your limits
   c. Talking with people you trust about your worries or problems
   d. Setting realistic goals
   e. Getting enough sleep
   f. Maintaining a reasonable diet
   g. Exercising regularly
   h. Taking vacations
   i. Practicing meditation
   j. Practicing self-hypnosis

k. Using positive imagery

l. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation

m. Participating in spiritual or cultural activities

7. Provide referrals as appropriate.

FMS-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. The test may be performed to rule out other disease processes.
2. Explain the necessity, the benefits and the 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.

FF - Formula Feeding

FF-FS FORMULA FEEDING SKILLS

OUTCOME: 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 the 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 one 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 healthcare professional.
7. Explain resources, such as WIC, for formula feeding and types.

FF-L LITERATURE

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

STANDARDS:

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

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 the mother to use breast binder or snug bra until swelling goes away.
3. Explain the signs of breast infection, such as sudden fever/malaise and need for pursuing medical evaluation.
4. Explain the current treatments for engorgement.

FF-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

FF-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.

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 five 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 Treatment" on page 569**.

5. Explain that boiling bottles and nipples for five 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 four 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 four 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 six 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 months 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 four years of age, e.g., 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 babies 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. Who will give you cues to readiness when they open their mouths when they see something coming
    c. Who will close lips over a spoon
    d. Who will keep food in their mouth instead of spitting it out
    e. Who 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 the 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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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. Those with a history of previous cold injuries
   d. Those who ingest particular drugs, e.g., 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 LITERATURE

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

STANDARDS:

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

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-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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 (e.g., 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 (e.g., 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, e.g., 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. Those with a history of previous cold injuries

d. Those who ingest particular drugs, e.g., 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 re-warmed under medical supervision.
3. Explain that the patient needs to get to a warm place where the patient can stay warm after thawing. Refreezing can cause more severe tissue damage.
4. Review proper thawing process:
   a. Use warm-to-the touch water 100F (38C.) 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, e.g., 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, e.g., increasing redness, purulent discharge, fever, increased swelling/pain.
4. Detail the supplies necessary for the care of this wound (if any) and how/where they might be obtained.
5. Emphasize the importance of follow-up.
6. Demonstrate the necessary wound care techniques.

G

GB - Gallbladder Disorders

GB-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

GB-C COMPLICATIONS

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

STANDARDS:

1. Explain that if the amount of bile and other chemicals inside the gallbladder get out of balance gallstones can form. Most gallstones are cholesterol gallstones and form when too much cholesterol is secreted into the gallbladder from the liver.
2. Explain that gallstones usually don't cause a problem if they stay in the gallbladder. Approximately 80% of people with gallstones have no symptoms at all.
3. Explain that sometimes gallstones move into the ducts that drain the gallbladder and that this may lead to pain, infections, diseases of the liver, disease of the pancreas and may lead to gangrene or perforation of the gallbladder.
4. Empyema of the gallbladder (pus in the gallbladder) is a serious complication of acute cholecystitis and can result in death in about 25% of cases. Empyema is relatively rare, however, it does occur in about 2% of cases of acute cholecystitis.

5. Explain that patients with choledocholithiasis (stones in the common bile ducts) may get cholangitis (infection of the bile ducts). This is very serious and may be treated with antibiotics and may require surgery. Choledocholithiasis may also result in pancreatitis. **Refer to "PC - Pancreatitis" on page 664.**
6. Explain that risk of serious complications can be reduced by seeking prompt medical attention.

GB-DP DISEASE PROCESS

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

STANDARDS:

1. Explain that gallstones (cholelithiasis) can cause problems when a gallstone gets lodged in either the cystic duct or the common bile duct. This can result in right upper quadrant abdominal pain, nausea, vomiting, heartburn, and back pain.
2. Explain that gallstones in the common bile duct can also result in jaundice or pancreatitis. This condition is called choledocholithiasis.
3. Explain that biliary colic is a mild form of gallbladder disease and results in right upper quadrant abdominal pain several hours after eating a fatty meal. The pain is not relieved by changes in position, over-the-counter medications or passing gas. It will usually spontaneously resolve in 1–5 hours.
4. Explain that acute cholecystitis is similar to biliary colic but is more severe. It results from inflammation of the gallbladder. Infection is often present. The pain with cholecystitis is more severe and often patients complain of pain with breathing. This is a severe condition which can progress to perforation of the gallbladder or gangrene. Patients with acute cholecystitis should seek immediate medical attention.
5. Explain that chronic cholecystitis results from long term inflammation of the gallbladder with or without stones and results in scarring of the gallbladder. Patients with chronic cholecystitis will often have gas, nausea or abdominal discomfort after meals.
6. Explain that some drugs may induce gall bladder disease.
7. Explain that gallbladder disease is more common in the following groups of people:
   a. Women
   b. People over 40

c. Women who have been pregnant (especially women with multiple pregnancies)

d. People who are overweight

e. People who eat large amounts of dairy products, animal fats, and fried foods, e.g., high fat diet

f. People who lose weight very rapidly

g. People with a family history of gallbladder disease

h. Native Americans (especially Pima Indians), Hispanics, and people of Northern European descent

i. People with sickle-cell anemia, cirrhosis, hypertriglyceridemia (especially with low HDL cholesterol), or diabetes

GB-FU FOLLOW-UP

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

STANDARDS:

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

GB-L LITERATURE

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

STANDARDS:

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

GB-M MEDICATIONS

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

STANDARDS:

1. Explain as indicated that some medications may be used to dissolve small gallstones.

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

GB-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

GB-N NUTRITION

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

STANDARDS:

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

GB-P PREVENTION

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

STANDARDS:

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

GB-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that pain management in gallbladder disease is specific to the disease process of this particular patient and may be multifaceted.
2. Explain that often antispasmodics may be helpful.
3. Explain that short term use of narcotics may be helpful in pain management.
4. Explain that other medications may be helpful to control the symptoms of nausea and vomiting.
5. Explain that administration of fluids may help with pain relief and resolution of symptoms.
6. **Refer to "PM - Pain Management" on page 657.**

GB-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure(s) as well as risks, benefits, and alternatives to the proposed procedure(s). **Refer to "SPE - Surgical Procedures and Endoscopy" on page 822.**

STANDARDS:

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

GB-TE TESTS

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

STANDARDS:

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

GE - Gastroenteritis

GE-C COMPLICATIONS

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

STANDARDS:

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

GE-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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, e.g., 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 LITERATURE

OUTCOME: The patient/family will receive literature about gastroenteritis.

STANDARDS:

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

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-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.

b. Identification of the patient's nutritional problem.
c. Identification of a specific nutrition intervention therapy plan.
d. Evaluation of the patient's nutritional care outcomes.
e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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 because they are dehydrating.
6. Explain that clear liquids taken in small amounts and frequently will often result in resolution of the vomiting, e.g., 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 - Pain Management" on page 657.**
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, e.g., 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 (GERD).

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 LITERATURE

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

STANDARDS:

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

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. **Refer to "GER-N Nutrition" on page 434**.
3. Discuss physical control measures such as elevating the head of the bed.

GER-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

GER-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of gastroesophageal reflux disease.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.

3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

GER-N NUTRITION

OUTCOME: The patient will understand the role of nutrition and gastroesophageal reflux disease.

STANDARDS:

1. Review normal nutritional needs for optimal health.
2. Explain the benefits of weight loss, low fat diet, and small frequent meals.
3. Explain that spicy or high acidic foods may worsen condition. Examples include tomatoes, chili, citrus fruits and juices, chocolate, peppermint, onions, garlic, alcohol, coffee, etc.
4. Discourage late evening meals and snacks. Instruct the patient to maintain an upright position for 2 hours after eating. Elevating the head of the bed at night may also be beneficial.
5. Discuss nutritional modifications as related to GER. Refer to a registered dietitian for MNT as appropriate.

GER-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain the pain scale and how it is used to assess the degree of pain individuals are experiencing. Discuss it's use in developing a plan to manage pain.
2. Explain that pain management is specific to the disease process of this particular diagnosis and may be multifaceted. **Refer to "PM - Pain Management" on page 657.**
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, e.g., sit upright, loosen clothing, breathe deeply.

GER-SM STRESS MANAGEMENT

OUTCOME: 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 healthy diet
   g. Exercising regularly
   h. Taking vacations
   i. Practicing meditation, self hypnosis, and positive imagery.
   j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   k. Participating in 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. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
2. Explain any necessary preparation and instructions for the test ordered.

a. Explain that upper gastrointestinal barium studies is an x-ray to assess the degree and extent of the disease.

b. Discuss the test(s) for *H. Pylori* and how testing may assist in diagnosis and treatment.

c. Discuss as appropriate the procedure for EGD. **Refer to "SPE - Surgical Procedures and Endoscopy" on page 822.**

3. Explain the meaning of the test results, as appropriate.

GER-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options and will participate in the design of the treatment plan, goals, and expected results.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options. Discuss with the patient/family the possible appropriate procedural or operative pain management techniques, e.g., medications, non- pharmacological, and surgical.
2. Discuss the treatment plan, including lifestyle adaptations, pharmacologic, surgical, and psychosocial aspects of the treatment plan.
3. Discuss the importance of fully participating in the treatment plan, including scheduled follow-up and physical therapy.

GAD - Generalized Anxiety Disorder

GAD-C COMPLICATIONS

OUTCOME: The patient/family will understand some of the complications associated with generalized anxiety disorder.

STANDARDS:

1. Discuss that GAD can cause major disruptions in family and work relationships. Refer to counseling or behavioral health services as appropriate.
2. Discuss that GAD can cause many physical symptoms such as chest pain, dizziness, abdominal pain, headaches, jaw pain, palpitations, shortness of breath, bruxism, broken teeth, fatigue, sleep disruption, and other physical symptoms. Generalized anxiety disorder is frequently misdiagnosed as cardiac or gastrointestinal disease.
3. Explain that untreated GAD may worsen and result in depression and/or suicide.

GAD-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

GAD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand some of the current information about cause and expected course of generalized anxiety disorder and will make a plan to obtain treatment, when appropriate.

STANDARDS:

1. Explain that GAD is a primary disorder in which the patient has a constant and severe sense of anxiety/fear which is not attributable to a specific stressor and is significant enough to interfere with work, home, or social functioning.
2. Explain that as of May, 2003, it is believed that GAD results from a dysfunction of the GABA neurotransmitter system in the brain. Discuss that GAD is a neurochemical/biological disorder and is not the result of a weak personality or inappropriate parenting. *(NOTE: This information is subject to change as new research is done. Providers are encouraged to seek information from an up-to-date primary source such as journal articles or textbooks.)*
3. Explain that symptoms of GAD may include difficulty sleeping, difficulty with concentration, unusual sense of fear in ordinary circumstances, stressed relationships, inability to work with others, unusual number of physical complaints for which a source cannot be found.
4. Explain that because the symptoms of GAD are numerous and non-specific, the diagnosis can only be made by a trained healthcare professional. Explain that because GAD has a tendency to run in families, the healthcare professional will likely request information about other family members.
5. Explain that generalized anxiety disorder is typically a chronic disease which is often progressive and may be associated with other mental/emotional disorders. (For example: agoraphobia, panic disorder, and/or depression.)
6. Explain that the symptoms of GAD may get better or worse at different times; symptoms will often worsen when the patient is more stressed, but symptoms may not be related to outside stressors. Explain that there is a tendency for GAD to worsen over time if it is not treated, but there are effective treatments available. **Refer to "GAD-TX Treatment" on page 441.**

GAD-EX EXERCISE

OUTCOME: The patient/family will understand the role of exercise in the treatment of generalized anxiety disorder.

STANDARDS:

1. Explain that it is believed that regular exercise favorably alters the chemistry of the brain by changing the levels of various neurotransmitter chemicals and by degrading ("burning up") stress hormones.
2. Explain that many physicians believe that exercise can be an important part of the treatment of GAD and other emotional disorders and that the patient's physician or other provider may prescribe exercise. As appropriate, encourage the patient to ask the physician or provider about starting an exercise program.
3. Explain that the optimal level of exercise may vary from patient-to-patient, but that 30 minutes of aerobic exercise (e.g., fast walking, bicycling, running, swimming laps) daily is usually enough to result in improvement in GAD symptoms. Encourage the patient to increase the intensity of the activity as the patient becomes more fit.
4. Explain that other forms of exercise (e.g., weight-lifting, sit-ups) as well as aerobic exercise may very well be helpful, but have not been studied. Encourage the patient to engage in whatever form of exercise the patient is able and willing to do. This may include increasing daily activities, e.g., gardening, house cleaning, dancing. Explain that most people should be evaluated by a physician or other provider before starting an exercise program. Refer to physician or provider as appropriate. Refer to community-based exercise program(s) as appropriate.
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles. Assist the patient in developing a personal exercise plan. **Refer to "HPDP-EX Exercise" on page 480.**

GAD-FU FOLLOW-UP

OUTCOME: The patient and/or family will understand the importance of follow-up in the treatment of generalized anxiety disorder.

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.

GAD-IR INFORMATION AND REFERRAL

OUTCOME: The patient/family will receive information and referral for alternative or additional services as needed or desired.

STANDARDS:

1. Provide the patient/family with alternative or additional sources for care and services.
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

GAD-L LITERATURE

OUTCOME: The patient/family will receive literature about generalized anxiety disorder.

STANDARDS:

1. Provide parent/family with literature on generalized anxiety disorder.
2. Discuss the content of the literature.

GAD-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

GAD-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in anxiety disorders.

STANDARDS:

1. Explain that uncontrolled stress is linked with the onset of major depression, contributes to more severe symptoms of anxiety, and can interfere with the treatment of anxiety disorders.

2. Explain that effective stress management may reduce the severity of the patient's symptoms as well as help improve health and well-being.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol, or other substance use as well as inappropriate eating, all of which can increase the severity of the anxiety and increase the risk of depression and suicidal behaviors.
4. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
   a. Becoming aware of your own reactions to stress
   b. Recognizing and accepting your limits
   c. Talking with people you trust about your worries or problems
   d. Setting realistic goals
   e. Getting enough sleep
   f. Maintaining a healthy diet
   g. Exercising regularly
   h. Taking vacations
   i. Practicing meditation, self-hypnosis, and positive imagery
   j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   k. Participating in spiritual or cultural activities
5. Provide referrals as appropriate.

GAD-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options that may be used to treat anxiety.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options. Explain that treatment for GAD may vary according to the patient's life circumstances, severity of the condition, and available resources.
2. Discuss the treatment plan, including lifestyle adaptation, pharmacologic, and psychosocial aspects of the treatment plan.
   a. Regular exercise will usually contribute significantly to improving the symptoms of GAD and in some cases will eliminate the need for medication. **Refer to "GAD-EX Exercise" on page 438.**

b. Medication may be prescribed on an individualized basis, according to need. **Refer to "GAD-M Medications" on page 440.**

c. Some form of counseling or psychotherapy will usually be prescribed initially and in some cases may be continued indefinitely.

3. Discuss the importance of fully participating in the treatment plan, including scheduled follow-up. Explain that GAD usually can be treated successfully, but that the patient's active participation in the treatment plan is critical to a good outcome.

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 (e.g., hypothyroidism, alantoaxial instability with Down syndrome.)

GENE-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving optimal physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

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 the 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 LITERATURE

OUTCOME: The parents/family will receive literature about the genetic disorder.

STANDARDS:

1. Provide the parents/family with literature about the genetic disorder.
2. Discuss the content of the literature.

GENE-LA LIFESTYLE ADAPTATIONS

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 parents must be advocates for their child with special needs (e.g., Birth to 3, Head Start, special school programs).
3. Refer to community services, resources, or support groups, as available.

GENE-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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 (e.g., 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 (e.g., 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 (e.g., 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 parents to have time for themselves.

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. Practicing self-hypnosis
   k. Using positive imagery
   l. Practicing relaxation methods such as deep breathing or progressive muscular relaxation
   m. Participating in 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. The 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.

GIB - GI Bleed

GIB-C COMPLICATIONS

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

STANDARDS:

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

GIB-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

GIB-DP DISEASE PROCESS

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

STANDARDS:

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

GIB-EQ EQUIPMENT

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

STANDARDS:

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

GIB-FU FOLLOW-UP

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

STANDARDS:

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

GIB-L LITERATURE

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

STANDARDS:

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

GIB-M MEDICATIONS

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

STANDARDS:

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

GIB-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

GIB-N NUTRITION

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

STANDARDS:

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

GIB-P PREVENTION

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

STANDARDS:

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

GIB-TE TESTS

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

STANDARDS:

1. Explain that examining a stool sample for occult blood is a simple and reliable method for determining subtle bleeding in the GI tract.

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

GIB-TX TREATMENT

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

STANDARDS:

1. Explain that IV fluids and/or blood transfusions may be necessary to replace lost blood volume. **Refer to "BL - Blood Transfusions" on page 131.**
2. Explain that for upper GI bleeding, gastric lavage may be necessary to remove the blood from the GI tract and prevent further complications.
3. Explain that electrocoagulation or photocoagulation (laser) may be necessary to stop the bleeding.
4. Explain that surgery may be necessary to resect the bleeding area or tumor if other measures are not effective.

GL - Glaucoma

GL-DP DISEASE PROCESS

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

STANDARDS:

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

GL-FU FOLLOW-UP

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

STANDARDS:

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

GL-L LITERATURE

OUTCOME: The patient/family will receive literature about glaucoma.

STANDARDS:

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

GL-LT LASER THERAPY

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

STANDARDS:

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

GL-M MEDICATIONS

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

STANDARDS:

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

GL-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.

Grief - Grief

GRIEF-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of unresolved grief.

STANDARDS:

1. Explain that grief becomes complicated when it is masked by significant physical/ behavioral symptoms, when it is exaggerated, ignored, or if grief from previous losses resurface.
2. Explain that complications of grief may include depressed or anxious mood, disturbed emotions and behavior, major depression, substance abuse, and posttraumatic stress disorder.
3. Emphasize that professional assistance may be needed to obtain full recovery from these complications. Encourage patients who suspect they have complications of grief to seek professional assistance/grief counseling.
4. Discuss that unresolved grief or survivor guilt may result in suicidal ideation and this should prompt immediate professional help.

GRIEF-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

1. Explain that the grieving process may be influenced by choices related to health and lifestyles, e.g., diet, exercise, sleep, stress management. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in dealing with grief, e.g. death and burial customs, prayer, faith.
3. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are interactions with prescribed treatment.
4. 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 dealing with grief.
5. Refer to clergy services, traditional healers, or other culturally appropriate resources.

GRIEF-DP DISEASE PROCESS

OUTCOME: The patient/family will understand what grief is and the process of healing.

STANDARDS:

1. Explain that grief is the reaction to a loss of something significant. Explain that grief may be experienced in response to physical losses, such as a death or home, or to symbolic or social losses such as the result of a divorce or loss of a job.
2. Explain that grief is a process to work through that takes time. Explain that grief has no timetable and emotions may arise for weeks, months, and even years. Explain that grief is difficult and painful and most individuals learn how to cope with the loss in time.
3. Explain that grief is a natural process and that individuals may react differently depending on the individual's personality, relationship to the loss, cultural and spiritual background, coping skills, mental history, and the support system.
4. Explain that anticipatory grief may also occur.

GRIEF-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of routine follow-up by the primary provider, social services, or mental health services as appropriate.
2. Assess the need for any additional follow-up and make the necessary referrals.

GRIEF-L LITERATURE

OUTCOME: The patient/family will receive literature about grief.

STANDARDS:

1. Provide the parent(s) and family with literature on grief.
2. Discuss the content of the literature.

GRIEF-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations that may assist in the grieving process.

STANDARDS:

1. Discuss some activities that facilitate grieving: (as culturally or individually appropriate)

a. Have a good cry.
b. Talk about the loss with reliable, compassionate friends.
c. Pray or meditate.
d. Forgive self/others for associated emotions such as anger, guilt, or embarrassment.
e. Have faith in the ability to heal.
f. Look for and focus on the positive and new opportunities.
g. Eat appropriately.
h. Exercise appropriately to sustain fitness and to clear the mind.
i. Participate in activities that are fun and distracting.
j. Arrange to be with friends during holidays or special events that are reminiscent of the loss.
k. Learn about grieving through informal support services, such as through a hospice.
l. Participate in a support group. (Support groups are available for parents who have lost a child, victims of drunk drivers, etc.)
m. Participate in counseling and support services, as appropriate.

GRIEF-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

GRIEF-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the need for and the goals of grief therapy.

STANDARDS:

1. Explain that grief therapy is sometimes indicated when individuals have complicated grief reactions.
2. Explain that the goal of grief therapy is to identify and resolve the conflicts of separation that interfere with the ability to mourn the loss.
3. Discuss that the objectives of grief counseling:
   a. Understanding the natural process of grief.
   b. Accepting and adjusting to the reality of the loss.
   c. Receiving affirmation for the "normalcy" of feelings.
   d. Providing information about the grief process and common grief responses.
   e. Understanding common obstacles and how to deal with them.
   f. Identifying and utilizing effective coping strategies.

GBS - Guillain-Barre Syndrome

GBS-C COMPLICATIONS

OUTCOME: The patient/family will understand the effects and consequences possible as a result of Guillain-Barre Syndrome and will understand that fully participating in the plan of care may help prevent these complications.

STANDARDS:

1. Explain that because of decreased inspiratory and expiratory capacities, coughing may become ineffective and the airway compromised, leading to hypoxia, atelectasis, pneumonia, and aspiration.
2. Explain that aspiration may also be the direct result of weakness of the laryngeal and glottic musculature, and that airway obstruction may occur as a result of tongue and retropharyngeal weakness.
3. Emphasize that changes in speech, tongue protrusion and swallowing problems are signs of impending respiratory dysfunction and should trigger an immediate visit to the healthcare provider.
4. Explain that another serious complication that can be treated with medications is cardiac rhythm disturbances.
5. Explain that other complications that are less serious, but still require treatment may be abnormal blood pressure, urinary retention, gastrointestinal dysfunction, and fluid and electrolyte abnormalities.
6. Explain that common complications of paralysis such as pressure sores and contractures may be minimized or eliminated by careful attention to skin care, positioning and passive exercise.

GBS-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology, symptoms and prognosis of Guillain-Barre Syndrome.

STANDARDS:

1. Explain to the patient that Guillain-Barre Syndrome is an inflammatory disease with widespread involvement of the peripheral and cranial nerves. It usually affects young adults and persons in their 50s. There is a higher incidence in men and Caucasians. The cause of the syndrome is unknown, but many persons with this syndrome experience a mild respiratory or gastrointestinal infection 1 to 3 weeks before the onset of the neuritic signs and symptoms. Viral infections may

function as a trigger to set off the autoimmune response to damage the peripheral nerves.

2. Explain that weakness usually begins in the distal muscles of the limbs, develops bilaterally over a period of a few days and ascends to the trunk, arms, and cranial muscles producing total motor paralysis within a few days (10 to 14 days.) This paralysis may involve the muscles of respiration and facial muscles so that the patient cannot breathe, chew, swallow, talk or open the eyes. Sensory symptoms may or may not be present.
3. Explain that muscle atrophy does not occur and the paralysis is usually temporary.
4. Explain that there is *usually* no pain, but tingling, burning, aching or cramping pain may occur.
5. Emphasize that recovery is usually total over time, but that convalescence may be lengthy and that recovery may continue from 3 months to 2 years.
6. Explain that there is a risk of recurrence. Persons who have experienced one episode of Guillain-Barre Syndrome are at higher risk of another episode over the general population.

GBS-EQ EQUIPMENT

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

STANDARDS:

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

GBS-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make plans to keep follow-up appointments and return immediately for signs of complications.

STANDARDS:

1. Stress the importance of keeping follow-up appointments and continuing the prescribed therapy even after the condition improves.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize the importance of keeping follow-up appointments.
4. Emphasize that changes in speech, tongue protrusion and swallowing problems are signs of impending respiratory dysfunction and should trigger an *immediate* visit to the healthcare provider or emergency facility.

GBS-L LITERATURE

OUTCOME: The patient/family will receive literature about Guillain-Barre Syndrome.

STANDARDS:

1. Provide the patient/family with literature on Guillain-Barre Syndrome.
2. Discuss the content of the literature.

GBS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will strive to make the lifestyle adaptations necessary to prevent complications of Guillain-Barre Syndrome and to improve mental and physical health.

STANDARDS:

1. Teach the patient to check the patient's feet daily for injuries. Minor injuries may go unnoticed because of sensory impairment.
2. Stress that over fatigue which decreases accuracy of motor coordination should be avoided.
3. Explain that career counseling may be needed if recovery of neurologic function is prolonged.
4. Encourage the patient/family to contact the Guillain-Barre Syndrome Support Group, International, P.O. Box 262, Wynnewood, PA 19096 for more information, newsletters, and a list of chapters.

GBS-M MEDICATIONS

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

STANDARDS:

1. Explain that the use of IV immunoglobulin has been found to reduce the clinical symptoms of Guillain-Barre Syndrome.
2. Explain that analgesics and muscle relaxants may be used for joint and muscle pain and muscle spasms.
3. Discuss the proper use, benefits, common side effects, and common interactions of the prescribed medications. Review the signs of possible toxicity and appropriate follow-up as indicated.
4. Emphasize the importance of fully participating in the medication regimen.
5. Emphasize the importance of consulting with a healthcare provider prior to initiating any new medications, including over-the-counter medications.
6. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

GBS-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

GBS-N NUTRITION

OUTCOME: The patient/family will understand the importance of maintaining or improving optimal nutritional status**.**

STANDARDS:

1. Explain that preventing or correcting weight loss that results in malnutrition is necessary to maintain optimal body function.
2. Explain that food textures may be modified as needed secondary to chewing or swallowing limitations (dysphagia).
3. Explain that it may be necessary to use oral supplements to meet energy needs. The use of vitamin/mineral supplements may be necessary.
4. As indicated, explain that nutrition may need to be maintained utilizing a feeding tube or parenteral nutrition during the most acute phases of illness.

GBS-TE TESTS

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

STANDARDS:

1. Explain that a spinal tap may be indicated to test for protein, which is usually elevated with Guillain-Barre Syndrome.
2. Explain that nerve conduction studies may be performed. Slowing of conduction velocity in peripheral nerves is present with Guillain-Barre Syndrome and may be used to monitor the course of the disease.
3. Explain that periodic pulmonary function studies may be done to screen for respiratory compromise so special care can be implemented in a timely manner.
4. Explain the benefits and risks of the test to be performed and how it relates to the course of treatment.

GBS-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available for Guillain-Barre Syndrome.

STANDARDS:

1. Explain that plasmapheresis produces temporary reduction in the circulating antibodies and sometimes an improvement in symptoms. Usually five exchanges are done within the first two weeks of symptoms for optimal results.
2. Explain that the treatment plan for Guillain-Barre Syndrome includes close monitoring of respiratory status and may include intubation and mechanical ventilation if the airway or respiratory status are compromised.

3. Explain that during the most acute phase, if indicated, cardiac monitoring will occur and dysrhythmias will be treated.
4. Explain that other treatment is supportive to prevent complications of immobility.
5. Emphasize that extensive rehabilitation is usually necessary for a full recovery.

H

HPS - Hantavirus Pulmonary Syndrome

HPS-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential consequences of exposure to and/or infection caused by the hantavirus.

STANDARDS:

1. Discuss the common or significant complications that may occur after infection with the hantavirus, such as cardiorespiratory failure and death.
2. Discuss if treatment is obtained before the disease progresses to acute respiratory distress, the chances of surviving are greatly increased.

HPS-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology, symptoms, and prognosis of infection with the hantavirus.

STANDARDS:

1. Explain that deer mice (along with cotton rats in the southeastern states and the white-footed mouse in the northeast) carry "hantaviruses" that cause hantavirus pulmonary syndrome (HPS). Explain rodents shed the virus in their urine, droppings, and saliva and the virus is mainly transmitted by people when they breathe in air contaminated by the virus.
2. Explain that following aerosol exposure and deposition of the virus deep in the lung, infection may be initiated. The virus attacks the lungs and infects the walls of the capillaries, making them leak, flooding the lungs with fluid.
3. Incubation time is not positively known, but it appears that symptoms may develop between one and five weeks after exposure.
4. Explain that symptoms include:
    a. Early universal symptoms: fatigue, fever, and muscle aches, especially in the large muscle groups – thighs, hips, back, and sometimes shoulders.
    b. Other early symptoms: headaches, dizziness, chills, and abdominal problems, such as nausea, vomiting, diarrhea, and abdominal pain (about half of all HPS patients experience these symptoms).
    c. Late symptoms (4 to 10 days): coughing and shortness of breath, with the sensation of a "tight band around the chest and a pillow over the face" as the lungs fill with fluid.

5. Discuss that even though the mortality rate is near 50% (2004 data), the sooner an infected person gets medical treatment, the better the chance of recovery. Explain the need to see the doctor immediately for exposure to rodents and development of symptoms of fever, deep muscle aches and severe shortness of breath. Emphasize the need to tell your physician that you have been around rodents.

HPS-EQ EQUIPMENT

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

STANDARDS:

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

HPS-FU FOLLOW-UP

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

STANDARDS:

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

HPS-INT INTUBATION

OUTCOME: The patient/family will have a basic understanding of endotracheal intubation, as well as, the risks, benefits, alternatives to endotracheal intubation and associated factors affecting the patient.

STANDARDS:

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

HPS-L LITERATURE

OUTCOME: The patient/family will receive literature about HPS.

STANDARDS:

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

HPS-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of HPS.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

HPS-P PREVENTION

OUTCOME: The patient/family will understand that HPS can be prevented by eliminating or minimizing contact with rodents.

STANDARDS:

1. Explain that rodents tend to be found in the home, cabin, workplace, orchards, out buildings, hay fields, or open fields.
2. Discuss the importance of keeping a clean and healthy home and yard to eliminate sources of nesting materials and sites.
3. Discuss the need to seal up the house to keep rodents out of the home. Examine for any gaps around roofing, attic spaces, vents, windows, and doors as well as for gaps under the sink and locations where water pipes come into the home.
4. Discuss the common signs that point to a rodent problem (e.g., rodent droppings, rodent nests, food containers that have been "chewed on," gnawing sound, or an unusual musky odor).
5. Discuss the mode of transmission of HPS is inhalation of infected rodent feces, so it is important to not stir up dust by sweeping up or vacuuming up droppings, urine, or nesting material.
6. Discuss precautions to take when cleaning up rodents and rodent droppings including wearing rubber or plastic gloves and spraying dead rodents, urine, or droppings with a disinfectant or a mixture of bleach water. Explain that contaminated gloves must be disinfected with a disinfectant or soap and warm water before taking them off.
7. Explain the need to thoroughly wet contaminated areas with a disinfectant to deactivate the virus. The most general purpose disinfectants and household detergents are effective. A solution prepared by mixing 1½ cups of household bleach in 1 gallon of water may be used in place of commercial disinfectant. Take up contaminated materials with a damp towel, then mop or sponge the area with disinfectant.
8. Discuss that when going into cabins or outbuildings that have been closed up for awhile, they should be opened and aired before cleaning due to the high probability of rodent infestation and the possibility of droppings and/or urine.

HPS-TE TESTS

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

STANDARDS:

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

5. Discuss the meaning of the test results, as appropriate.

HPS-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available for HPS.

STANDARDS:

1. Explain to patient/family that there is currently no virus-killing drug that is effective against HPS.
2. Explain that there is no specific treatment or "cure" for hantavirus infection. If the infected individuals are recognized early and admitted to intensive care, the chance for recovery is better.
3. Emphasize that treatment is supportive care.

HPS-VENT MECHANICAL VENTILATION

OUTCOME: The patient/family will understand mechanical ventilation, as well as, the risks, benefits, alternatives to mechanical ventilation and associated factors affecting the patient.

STANDARDS:

1. Explain that the patient must be intubated with an endotracheal tube or tracheostomy tube in order to receive mechanical ventilation.
2. Explain the basic mechanics of mechanical ventilation, including the risks and benefits of receiving mechanical ventilation and the adverse events which might result from refusal.
3. Discuss alternatives to mechanical ventilation, including expectant management, as appropriate.
4. Explain that the patient will be unable to speak or eat while intubated and receiving mechanical ventilation.
5. Explain that the patient will be sedated during intubation and the initiation of mechanical ventilation.
6. Discuss the possibility that the patient may require restraints to prevent accidental extubation.

HA - Headaches

HA-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

HA-C COMPLICATIONS

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

STANDARDS

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

HA-DP DISEASE PROCESS

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

STANDARDS:

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

HA-FU FOLLOW-UP

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

STANDARDS:

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

HA-L LITERATURE

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

STANDARDS:

1. Provide the patient/family with literature on headache pain.
2. Discuss the content of the literature.

HA-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

HA-M MEDICATIONS

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

STANDARDS:

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

7. Discuss the use of adjunct medications, if indicated, to control analgesic side effects, e.g., anti-emetics, laxatives, antacids.

HA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

HA-N NUTRITION

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

STANDARDS:

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

HA-P PREVENTION

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

STANDARDS:

1. Discuss strategies for identifying headache triggers (e.g., journal, activity, and food log).
2. Stress the importance of avoiding any known triggers.
3. Discuss that prophylactic medications must be taken as directed to be effective.
4. Emphasize that headaches seem to be more common during stressful times. **Refer to "HA-SM STRESS MANAGEMENT" on page 476.**

HA-PSY PSYCHOTHERAPY

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

STANDARDS:

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

HA-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress may exacerbate the symptoms of headache. This can set up a cycle of pain-stress which becomes self-sustaining and may escalate.
2. Discuss that in chronic headaches, uncontrolled stress may lead to depression or other mood disorders.

3. Explain that effective stress management may reduce the severity of symptoms the patient experiences, as well as help improve the health and well-being of the patient.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol, or other substance use as well as inappropriate eating, all which can increase the severity of pain.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
   a. Becoming aware of your own reactions to stress
   b. Recognizing and accepting your limits
   c. Talking with people you trust about your worries or problems
   d. Setting realistic goals
   e. Getting enough sleep
   f. Maintaining a reasonable diet
   g. Exercising regularly
   h. Taking vacations
   i. Practicing meditation
   j. Practicing self-hypnosis
   k. Using positive imagery
   l. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   m. Participating in spiritual or cultural activities
6. Provide referrals as appropriate.

HA-TE TESTS

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

STANDARDS:

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

5. Discuss the meaning of the test results, as appropriate.

HA-TX TREATMENT

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

STANDARDS:

1. Discuss with the patient/family the possible appropriate noninvasive pain relief measures, e.g., massage, heat, cold, rest, over-the-counter medications, books, or tapes for relaxation.
2. Discuss with the patient/family the possible alternative pain relief measures, when appropriate, e.g., meditation, imagery, acupuncture, healing touch traditional healer, biofeedback, hypnosis.
3. Discuss with the patient/family the possible appropriate pharmacotherapy. **Refer to "HA-M MEDICATIONs" on page 474.**
4. Discuss with the patient/family other possible approaches, e.g., lifestyle changes, physical therapy, nutritional changes, stress management, or psychotherapy.
5. Emphasize the importance of the patient/family's active involvement in the development of a treatment plan.

HPDP - Health Promotion Disease Prevention

HPDP-ADL ACTIVITIES OF DAILY LIVING

OUTCOME: The patient/family will understand how the patient's ability to perform activities of daily living (ADLs) impact the care plan including in-home and out-of-home care.

STANDARDS:

1. Define activities of daily living (ADLs) (e.g., the everyday activities involved in personal care such as feeding, dressing, bathing, moving from a bed to a chair (also called transferring), toileting, and walking) and discuss how the patient's ability to perform ADLs affects the patient's ability to live independently.
2. Assist the patient/family in assessing the patient's ability to perform activities of daily living.
3. Provide the appropriate information and referrals for services needed to increase, maintain, and/or assist with activities of daily living.

HPDP-CAR AUTOMOBILE SAFETY

OUTCOME: The patient/family will understand measures that will improve car safety.

STANDARDS:

1. Discuss the importance of using a seat belt when traveling in a vehicle.
2. Explain that the youngest child should be restrained in a car seat in the middle of the back seat of the vehicle.
3. Explain the dangers posed by things that might divert attention from driving, such as smoking, cell phone use, eating, CDs and radios, etc.
4. Emphasize the importance of never driving while under the influence of alcohol, sedatives, and/or street drugs.
5. Discuss the dangers in riding on the outside of the vehicle, such as in the back of a pick-up truck, on the hood of the vehicle, or on running boards of a vehicle.
6. Emphasize not to leave sibling/infant/child unattended in a vehicle (motor running, not running, keys in car) due to potential incidents; e.g., vehicle gears shifted and car goes in motion, electric windows cause injury to child, keys locked in vehicle with child, heat/cold exposure, abduction, or child wandering away.

HPDP-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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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.

HPDP-EX EXERCISE

OUTCOME: The patient will relate exercise and/or physical fitness to health promotion and disease prevention.

STANDARDS:

1. Review the benefits of regular exercise.
2. Discuss the three types of exercise: aerobic, flexibility, and endurance.
3. Review the basic recommendations of any exercise program:
4. If any chronic health problems exist, consult with a healthcare provider.
5. Start out slowly.
6. Exercise a minimum of three times a week.
7. Review the exercise programs available in the community.

HPDP-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Review the procedure for obtaining follow-up care.

3. Emphasize the importance of keeping appointments.

HPDP-HY HYGIENE

OUTCOME: The patient will recognize personal routine hygiene as an important part of wellness.

STANDARDS:

1. Review bathing habits, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
2. Review the importance of daily dental hygiene, with attention to brushing and flossing.
3. Discuss the importance of hand-washing in infection control, especially in relationship to food preparation/consumption, child care, and toilet use.
4. Discuss the importance of covering the mouth when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

HPDP-L LITERATURE

OUTCOME: The patient/family will receive literature about health promotion and disease prevention.

STANDARDS:

1. Provide the patient/family literature about health promotion and disease prevention.
2. Discuss the content of the literature.

HPDP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will be able to explain at least one lifestyle change necessary to improve mental or physical health.

STANDARDS:

1. Review the concept that health or wellness refers to the whole person (mind, body, and spirit) and is a positive state of health which results from appropriate habits and lifestyle.
2. Review lifestyle aspects/changes that the patient has control over: diet, exercise, safety and injury prevention, and avoidance of high risk behaviors (e.g. smoking, alcohol and substance abuse, sex with multiple partners).
3. Discuss wellness as an individual responsibility to:

a. Learn how to be healthy.
b. Be willing to change.
c. Practice new knowledge.
d. Get help when necessary.

4. Review the community resources available for help in achieving behavior changes.

HPDP-M MEDICATIONS

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

STANDARDS:

1. Review proper use, actions, 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 proper storage and handling of medications.

HPDP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

HPDP-N NUTRITION

OUTCOME: The patient will relate diet to health promotion and disease prevention.

STANDARDS:

1. Assess the current nutritional habits.
2. Discuss the importance of the food pyramid.
3. Review the relationship of calories to energy balance and body weight.
4. Emphasize the importance of limiting snack foods, fatty foods, red meats, reducing sodium consumption, and adding more fresh fruits, fresh vegetables, and fiber to the diet.
5. Emphasize the necessary component—WATER—in a healthy diet. Reduce the use of colas, coffee, and alcohol.
6. Review which community resources exist to assist with diet modification and weight control.
7. Stress the importance of being a smart shopper.

HPDP-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient will be able to identify at least one way to reduce injury risk.

STANDARDS:

1. Discuss the importance of vehicle safety:
    a. Regular use of seat belts and children's car seats, obeying the speed limit, and avoiding the use of alcohol while in a vehicle.
    b. Wear personal protective equipment when operating recreational vehicles (e.g., boats, snow mobiles, sea dos, ATVs, skateboards, bicycles.), and horses.
    c. **Never** leave children unattended in a vehicle.
    d. Never ride on the hood, bumper, or in the cargo compartment of any vehicle.
2. Discuss the importance of poisoning prevention:
    a. Discuss poison prevention: e.g., proper storage and safe use of medicines, cleaners, auto products, paints.
    b. Discuss current recommendations for use of ipecac syrup.
    c. Discuss common poisonous plants.
3. Discuss the importance of fire safety and burn prevention:
    a. Review the dangers inherent in the use of wood-burning stoves, "charcoal pans," kerosene heaters, and other open flames.

b. Encourage the use and proper maintenance of smoke detectors, carbon monoxide detectors, and fire suppression systems.

c. Encourage routine practices of fire escape plans, chimney cleaning, and fireworks safety.

d. Review the safe use of electricity and natural gas.

e. Encourage hot water heater no hotter than 120°F to avoid scalding.

f. Cook on the backburners of the stove and turn panhandles toward the back of the stove.

g. Avoid the use of kerosene or gasoline when burning debris piles.

4. Discuss the proper handling, storage, and disposal of hazardous items and materials:

   a. Firearms and other potentially hazardous tools.

   b. Waste, including sharps and hazardous materials.

   c. Chemicals, including antifreeze.

   d. Lead based materials, e.g., pre-1970 paint, pottery, smelting, pre-1993 window blinds, solder, old plumbing.

   e. Never store hazardous chemicals in food containers.

5. Discuss the importance of water safety:

   a. Never swim alone.

   b. Never leave a child unattended in a bathtub, swimming pool, lake, river, or other water source.

   c. Always close toilets, mop buckets, and other water containers to avoid toddler drowning.

6. Discuss the importance of food and drinking water safety:

   a. Proper handling, storage, and preparation of food, e.g., original preparation, reheating to a proper temperature (165°F).

   b. Importance of uncontaminated water sources. Discuss the importance of purifying any suspect water by boiling or chemical purification.

   c. Prevention of botulism, salmonella, shigella, giardia, listeria, E-coli, etc.

7. Identify which community resources promote safety and injury prevention. Provide information regarding key contacts for emergencies, e.g., 911, Poison Control, hospital ER, police.

HPDP-SCR SCREENING

OUTCOME: The patient/family will understand the proposed screening test including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed screening test, e.g., guaiac, blood pressure, hearing, vision, development, mental health.
2. Explain the process and what to expect after the test.
3. Emphasize the importance of follow-up care.

HPDP-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in overall health and well-being.

STANDARDS:

1. Explain that uncontrolled stress may cause release of stress hormones that interfere with general health and well-being.
2. Explain that effective stress management may help prevent progression of many disease states, 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, as well as, overeating, all of which can increase the risk of morbidity and mortality from many disease states.
4. Emphasize the importance of seeking professional help as needed to reduce stress.
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. Practicing self-hypnosis
    k. Using positive imagery
    l. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. Participating in spiritual or cultural activities

6. Provide referrals as appropriate.

HPDP-SX SEXUALITY

OUTCOME: The patient will understand how sexuality relates to wellness.

STANDARDS:

1. Review sexuality as an integral part of emotional and physical health.
2. Discuss how sexual feelings play a part in each person's personal identity.
3. Discuss sexual feelings as an important part of interpersonal relationships.
4. Discuss how sexuality varies with gender, age, life-stage, and relationship status.
5. Explain the preventive measures for STIs (**refer to "STI-P Prevention" on page 788**), including abstinence and monogamy.
6. Review the community resources available for sexual counseling or examination.

HPDP-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.

HRA - Hearing Aids

HRA-EQ EQUIPMENT

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

STANDARDS:

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

HRA-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care, including the importance of assessing the effectiveness of hearing aids and correcting problems that may develop.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

HRA-HY HYGIENE

OUTCOME: The patient/family will recognize good personal hygiene with regard to hearing aid usage.

STANDARDS:

1. Review the importance of maintaining good personal hygiene to avoid ear canal infection.
2. Emphasize that prior to baths and showers, the hearing aid must be removed and that the ear canal should be dry before re-inserting the hearing aid.

HRA-L LITERATURE

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

STANDARDS:

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

HRA-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

1. Discuss the importance of adjusting to the hearing aid; maintaining hygiene, and keeping the hearing aid in optimal working order.
2. Discuss that the hearing aid may be initially uncomfortable but with continued wear most people adjust.
3. Discuss the role of hearing aids, speech-reading, speech characteristics, and control of environmental factors in the communication process.
4. Refer to community resources as appropriate.

HL - Hearing Loss

HL-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the anatomy and physiology as it relates to hearing loss.

STANDARDS:

1. Discuss normal anatomy and physiology of the ear and hearing.
2. Discuss the changes to anatomy/physiology that have caused the hearing loss.

HL-C COMPLICATIONS

OUTCOME: The patient/family will understand some complications related to hearing loss.

STANDARDS:

1. Explain that the ability to hear is necessary to develop speech/language skills and may be a barrier to learning.
2. Discuss that profound hearing loss may result in increased risk of accidents due to the inability to hear warning noises.
3. Explain that social withdrawal and isolation may occur.
4. Refer to the local public school or other community resources as appropriate.

HL-DP DISEASE PROCESS

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

STANDARDS:

1. Explain the basic anatomy/physiology of hearing as appropriate.
2. Explain the type of hearing loss that applies to this patient:
    a. Conductive hearing loss occur when sound is not conducted efficiently through the outer ear canal to the ear drum, i.e., fluid in the middle ear from colds, allergies, ear infections (otitis media), poor eustachian tube function, impacted ear wax, presence of foreign bodies.
    b. Sensorineural Hearing Loss: occurs when there is damage to the inner ear (cochlea) or to the nerve pathways from the inner ear to the brain. Sensiorineural hearing loss cannot be medically or surgically corrected. It is permanent hearing loss. Noise induced hearing loss is a type of sensorineural hearing loss.

c. Mixed hearing loss is a combination of the above.

HL-EQ EQUIPMENT

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

STANDARDS:

1. Discuss equipment to be used in hearing loss. **Refer to "HRA - Hearing Aids" on page 487.**
2. Discuss and/or demonstrate proper use and care of equipment; participate in return demonstration by patient/family as appropriate.
3. Emphasize proper cleaning of equipment.

HL-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

HL-L LITERATURE

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

STANDARDS:

1. Provide the patient/family with literature on hearing loss.
2. Discuss the content of the literature.

HL-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations related to hearing loss.

STANDARDS:

1. Discuss the importance of wearing hearing aids as prescribed.
2. Discuss other assistive devices that may be part of life as a result of profound hearing loss.
3. Discuss sign language and lip reading as appropriate.
4. Discuss vanity and social stigmata as appropriate.

HL-P PREVENTION

OUTCOME: The patient/family will understand measures that may prevent hearing loss.

STANDARDS:

1. Discuss that hearing loss may not be preventable and may be the result of congenital anomalies, use of ototoxic medications, infections, etc.
2. Explain that Noise-Induced Hearing Loss (NIHL) is preventable. Discuss noises which can cause damage (those above 85 decibels). Examples include lawn mowers, chain saws, snowmobiles, motorcycles, firecrackers, hair dryers (primarily because the hair dyer is held close to the ear), firearms, and loud music.
3. Encourage the use of earplugs or earmuffs or other hearing protective devices. Explain the importance of using hearing protection for children who are too young to protect themselves.

HL-SCR SCREENING

OUTCOME: The patient/family will understand screening that may detect hearing loss.

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. Discuss the importance of follow up for screenings that indicate possible hearing loss.

HL-SL SPEECH AND LANGUAGE **REFER TO "HL-C Complications" on page 489**

HL-TE TESTS

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

STANDARDS:

1. Discuss the test/procedure and collection method to be performed.
2. Explain the patient's hearing test results.
3. Explain the relationship between the test results and communication abilities.

HL-TX TREATMENT

OUTCOME: The patient/family will understand various treatment options.

STANDARDS:

1. Explain that treatment depends on the cause of hearing loss. Emphasize that not all hearing loss is treatable and that while there is no cure for age-related hearing loss (Presbycusis), hearing aids may improve age-related hearing loss.
2. Explain that a middle ear infection that has resulted in hearing loss may be treated with antibiotics; blockages of the outer and middle ears can be cleared; damaged eardrums can be repaired surgically; and ossicles affected by otosclerosis can be replaced with artificial bones. Some causes of sensorineural hearing loss can also be improved.
3. A cochlear implant may help when a hearing aid does not give sufficient amplification. This device transmits sound directly into the auditory nerve via electrodes surgically implanted into the cochlea. A cochlear implant results in sounds being heard as buzzing or electronic in nature; implants can be very useful when used in combination with lip reading.

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, that 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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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, e.g., 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 LITERATURE

OUTCOME: The patient and/or family will receive literature about heatstroke, and important preventive measures.

STANDARDS:

1. Provide patient/family with literature on heatstroke and prevention of heatstroke.
2. Discuss the content of the literature.

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-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

HEAT-N NUTRITION

OUTCOME: The patient/family will understand the importance of adequate hydration and that water is the beverage of choice.

STANDARDS:

1. Explain that water is the beverage that best hydrates the body.
2. Discuss that caffeinated beverages and alcohol are especially dangerous and may predispose to dehydration and heat stroke.

HEAT-P PREVENTION

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

STANDARDS:

1. Discuss that it is easier to prevent heat stroke than to treat it.
2. Discuss with the patient/family that the majority of heat stroke cases are preventable by avoiding extremely hot/humid environments, inadequately ventilated spaces, inadequate fluid intake and heavy clothing in warm conditions.

3. Discuss with the patient/family ways to prevent heatstroke when heat exposure cannot be avoided; reducing or eliminating strenuous activities, staying adequately hydrated, frequently taking showers, wearing light weight clothing, and avoiding direct sunlight.
4. Discuss that up to a liter an hour may be required to prevent dehydration and predispose to heat stroke.
5. Discuss with the patient the most likely time of year to develop heatstroke: summer.
6. Discuss with patient the risk factors such as increased age, debility, low fluid intake, excessive exercise, alcohol and drug use, chronic disease, living conditions with no air-conditioning, travel to warmer climates, and prolonged outdoor activities.

HEAT-TE TESTS

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

STANDARDS:

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

HEAT-TX TREATMENT

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

STANDARDS:

1. Discuss the importance of seeking emergency care if heatstroke is suspected.
2. Discuss the importance of slowly decreasing the temperature of the person.
3. Discuss the management of heatstroke in the emergency department; protection of airway, intravenous administration of fluids, monitoring of temperature, decreasing of temperature, and monitoring of cardiorespiratory status.

4. Discuss the goal of treatment with the patient; prevention of further heat loss, decrease in the core body temperature, and management and prevention of complications.
5. Discuss with the patient/family the importance of seeking emergency help as soon as possible in the incidence of a heatstroke.
6. Discuss the probability that the person experiencing a heatstroke may be admitted to an intensive care unit for extensive monitoring.

HEP - Hepatitis A,B,C

HEP-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family/caregiver will understand the basic function of the liver and its relationship to hepatitis.

STANDARDS:

1. Briefly identify and explain the function of the liver.
2. Discuss the liver's role in detoxifying and cleansing the body.
3. Explain the word "hepatitis" means inflammation of the liver.
4. Explain that common viral infections that affect the liver include Hepatitis A, Hepatitis B, and Hepatitis C.

HEP-C COMPLICATIONS

OUTCOME: The patient/family/caregiver will understand the long term consequences of viral infections with HAV, HBV, and HCV. The patient will learn how to protect the liver from further harm.

STANDARDS:

1. Explain that most persons who get HCV carry the virus the rest of their lives and most of these have some liver damage. Some may develop cirrhosis (scarring) of the liver or liver failure.
2. Discuss ways to care for the liver:
   a. Avoid alcoholic beverages
   b. Inform your provider of all the medications, even over the counter and herbals medication
   c. Have regular doctor visits
   d. Get vaccinated against Hepatitis A and B
3. Explain that the most common symptom with long term hepatitis C is extreme tiredness.

HEP-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving optimal physical and behavioral health.

STANDARDS:

1. Discuss the roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to** **"AF-CON Confidentiality" on page 33**.

HEP-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

HEP-DPA DISEASE PROCESS HEPATITIS A

OUTCOME: The patient/family or caregiver will understand that hep A is an inflammation of the liver caused by hepatitis A virus (HAV).

STANDARDS:

1. Explain that the symptoms of HAV infection will usually last for about 3 weeks.

2. Discuss that the patient's symptoms may include fever, nausea, vomiting, jaundice, diarrhea, fatigue, abdominal pain, dark urine, and appetite loss.
3. Emphasize that other symptoms such as respiratory symptoms, rash, and joint pain may also develop.
4. Explain to the patient/family that in the early stages of infection the virus is easily transmitted to others by contact with body fluids and excrements (usually fecal/ oral route).
5. Explain that in children the disease is usually mild and may even be asymptomatic.

HEP-DPB DISEASE PROCESS HEPATITIS B

OUTCOME: The patient/family/caregiver will understand that hepatitis B is an inflammation of the liver caused by infection with Hepatitis B virus (HBV).

STANDARDS:

1. Review the transmission modes, known risk groups and child exposure.
2. Discuss the symptoms of acute HBV: nausea, vomiting, jaundice, rash, abdominal pain, malaise, fever may be absent or mild.
3. Discuss that following acute infection with HBV one may become a carrier, resolve the disease, or develop chronic Hepatitis B.
4. Discuss the symptoms of chronic HBV: including malaise, anorexia, weight loss, fatigue, cirrhosis and predisposition to liver cancer.
5. Explain that HBV is a blood born pathogen and is spread by contact with contaminated blood or other body fluids. The most common ways to get it are through unprotected sex, sharing needles, sharing personal items, or by perinatal transmission.

HEP-DPC DISEASE PROCESS HEPATITIS C

OUTCOME: The patient, family or caregiver will understand that hepatitis C is a liver disease caused by infection with Hepatitis C virus (HCV) which is found in the blood of persons with the disease. Formerly called non-A, non-B is the most common chronic blood borne viral infection.

STANDARDS:

1. Explain that Hepatitis C is an infection transmitted primarily by blood. Explain that 85% of persons infected with HCV cannot clear the infection and the virus continues to multiply in the body. As a result, chronic infection occurs and may be contagious.

2. Discuss the primary risk factors associated with HCV, e.g., sharing needles when injecting drugs and exposure to blood in the healthcare setting. Sexual transmission may occur but is low. Blood transfusion associated cases are now rare.
3. Discuss the signs and symptoms of HCV: jaundice, fatigue, abdominal pain, loss of appetite, and bouts of nausea and vomiting. (1 in 10 people will have symptoms when initially infected).
4. Differentiate between acute and chronic infection. Note that it could be years before person with chronic infection may experience symptoms serious enough to prompt seeking medical care. Consequences may appear 10–20 years after infection.
5. Discuss that chronic HCV may result in cirrhosis and/or liver cancer.

HEP-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand the need for keeping appointments for medical follow-up and immunization as appropriate.

STANDARDS:

1. Explain that persons with hepatitis C may need to consider immunization against Hepatitis A and B to prevent further liver damage.
2. Discuss the importance of follow-up care.
3. Encourage the patient to keep follow-up appointments.
4. Refer to community resources as appropriate.

HEP-L LITERATURE

OUTCOME: The patient/family or caregiver will receive literature about hepatitis, vaccine information or preventive measures.

STANDARDS:

1. Provide patient/family with literature n on hepatitis, vaccine information, and/or preventive/protective measures.
2. Discuss the content of the literature.

HEP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adaptations necessary for healing and performance of daily living activities.

STANDARDS:

1. Review lifestyle areas that may require adaptations such as:
   a. Having sexual activity
   b. Traveling
   c. Avoiding alcohol use and illegal drug use
   d. Avoiding the intake of foods that may be at high risk for transmission of Hepatitis A

HEP-M MEDICATIONS

OUTCOME: Patient/Family with understand medications to manage hepatitis.

STANDARDS:

1. Review the proper use, benefits, and common side effects of the prescribed medication.
2. Emphasize the importance of adhering to medication regimen.
3. Emphasize the importance of possible drug interactions with foods, drugs, herbals, oral nutritional supplements, over the counter medications, as appropriate.

HEP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

HEP-N NUTRITION

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

STANDARDS:

1. Discuss current nutritional habits and needs. Address anorexia and weight loss as appropriate.
2. Emphasize the necessary component, water, in a healthy diet.
3. Review the patient's prescribed diet if applicable.
4. Refer to registered dietician or other local resources as indicated.

HEP-P PREVENTION

OUTCOME: The patient/family/caregiver will understand the modes of transmission, ways to prevent acquiring the virus.

STANDARDS:

1. The best way to prevent exposure to virus is by careful hand washing. Review standard precautions for use by child care workers, healthcare workers, corrections officers, and food service workers.
2. Discuss immunization against Hepatitis A and B as methods of prevention.
3. Explain that there is no vaccine for prevention of hepatitis C.
4. Discuss the use of immunoglobulin against Hep A and B for post exposure prophylaxis.
5. Explain that hepatitis A is generally spread by fecal - oral route. Careful hand washing is paramount.
6. Explain that hepatitis B and C are spread by blood contact. Standard precautions are paramount. Do not share personal items such as toothbrushes, razors, or needles.
7. Hepatitis B can be spread by sexual transmission. Adequate protective barriers are important.
8. Persons with hepatitis should not donate plasma, blood, sperm, or organs because this may spread the virus to others.

HEP-TE TESTS

OUTCOME: The patient/family or caregiver will understand the importance of testing.

STANDARDS:

1. Discuss the need for testing if you think you have been exposed to Hepatitis A, B, or C.
2. Explain that if you test positive, further testing may be necessary.

HEP-TX TREATMENT

OUTCOME: The patient/family or caregiver will understand treatment for Hepatitis A, B, or C.

STANDARDS:

1. Explain that some antiviral medications may be helpful in the treatment of hepatitis.
2. Discuss current treatment options.
3. Discuss the importance of protecting the liver from further harm by not drinking alcohol, getting vaccinated against Hepatitis A and B.
4. Advise against starting any new prescription or over the counter medication, herbal products, and oral nutritional supplements without first discussing hepatitis status with the provider.
5. Emphasize the importance of rest and proper nutrition in recovery from hepatitis.

HIV - Human Immunodeficiency Virus

HIV-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family/caregiver will understand the process of developing an advance directive and its role in maintaining a sense of control in the patient's medical care and decisions.

STANDARDS:

1. Explain that patients may lose the ability to make their own decisions and an advance directive will be able to express the patient's desires prior to the loss of decision-making abilities.
2. Review the option of Advanced Directives/Living Will with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
3. Refer to appropriate services to assist the patient in making a living will, e.g., Social Services, Clergy, Lawyer.
4. **Refer to "ADV - Advance Directives" on page 40**.

HIV-C COMPLICATIONS

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

STANDARDS:

1. Discuss the common or significant complications associated with HIV/AIDS:
   a. Bacterial infections
   b. Viral infections
   c. Fungal infections
   d. Parasitic infections
   e. Cancers
2. Discuss common or significant complications that may be prevented by full participation with the treatment regimen.
3. Discuss common or significant complications that may result from treatment(s).

HIV-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

HIV-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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. Discuss role and importance of familial support in addressing the many potential psychosocial effects of diagnosis including:
    a. Family identity overriding individual identity and needs
    b. Social isolation
    c. Guilt
    d. Stigma and discrimination
    e. Normalization of the disease (treat like other chronic disease, e.g., hypertension.)
    f. Follow-up, support, and access to medical care
4. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are interactions with prescribed treatment.
5. Discuss that traditions, such as sweat lodges, may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.

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

HIV-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the risk factors, methods of transmission and prevention of HIV (Human Immunodeficiency Virus), and the progression from HIV positive status to AIDS (acquired immunodeficiency syndrome).

STANDARDS:

1. Explain the methods of HIV transmissions, e.g., semen, blood and blood product transfusions, needle sharing, accidental needle sticks, vaginal fluids, mother to infant, and in rare cases, organ or tissue transplants, and unsterilized dental or surgical equipment.
2. Discuss that sexual preference does not affect acquisition or transmission of the virus. The virus in non-selective and a risk to all.
3. Explain that HIV is a virus and there is no current vaccine to prevent its occurrence.
4. Explain that the human immunodeficiency virus attacks the immune system resulting in increased susceptibility to infections and cancers.
5. Explain the difference between HIV infection and AIDS. Explain that it is currently believed that all HIV infections will progress to AIDS. Early treatment and strict participation may slow the progression from HIV infection to AIDS.
6. Some symptoms of AIDS may be unusual or more frequent infections that are especially difficult to treat.
7. Explain the current knowledge about the progression of HIV and AIDS.

HIV-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment. Emphasize the importance of not tampering with any medical device.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate the proper use, care, and cleaning of medical equipment. Discuss proper disposal of associated medical supplies.
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. 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.

HIV-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care with referral resources and assistance from HIV case managers.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

HIV-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand how to manage HIV/AIDS at home.

STANDARDS:

1. Discuss the risks and benefits of the use of over the counter medications for symptom relief.
2. Discuss the use of alternative therapies or complementary medicinals that may be useful in symptom relief.
3. Help the patient/family to identify appropriate resources for managing HIV/AIDS at home.
4. Discuss the identification and confirmation of continuous familial (or other) support structure.

HIV-HY HYGIENE

OUTCOME: The patient will recognize good personal hygiene as an important component of preventing complications.

STANDARDS:

1. Discuss hygiene as part of a positive self image.
2. Review bathing and daily dental hygiene habits, e.g., don't share razors and toothbrushes.
3. Discuss the importance of hand washing in infection control.
4. If using IV drugs, discuss the importance and implications of not sharing needles and discuss the proper disposal of used needles.
5. Discuss the importance and implications of preventing unprotected sexual activity:
   a. Use a new latex or polyurethane condom every time you have vaginal or anal sex. Condoms other than latex or polyurethane are not effective in the prevention of HIV.
   b. During oral sex use a condom, dental dam, or plastic wrap.
   c. If you use sexual devices, don't share them.
   d. Don't share razor blades or tooth brushes.
6. Discuss any hygiene habits that are specifically pertinent to this disease state or condition.

HIV-L LITERATURE

OUTCOME: The patient/family/caregiver will receive literature about HIV and other sexually transmitted infections (STIs).

STANDARDS:

1. Provide patient/family with literature on HIV and/or other sexually transmitted infections.
2. Discuss the content of literature.
3. Caution the patient that information found on the Internet is not necessarily screened for accuracy and may not be correct. Emphasize the importance of using reliable sources of information.

HIV-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

1. Review lifestyle aspects/changes that the patient has control over - diet, exercise, safety and injury prevention, avoidance of high risk behaviors, and full participation with treatment plan:
   a. Follow safer sex practices
   b. Tell your sexual partner(s) that you have HIV
   c. If your partner is pregnant, tell her you have HIV
   d. Tell others who need to know, e.g., family, friends, health providers
   e. Don't share needles or syringes
   f. Don't donate blood or organs
   g. If you are pregnant, get medical care right away
2. Emphasize that an important component in the prevention or treatment of disease is the patient's adaptation to a healthier, lower risk lifestyle.
3. Emphasize the importance of not smoking, using illegal drugs, or alcohol as these further weaken your body.
4. Review the community resources available to assist the patient in making lifestyle changes. Refer as appropriate.
5. Discuss availability or access to involvement /support from another person living with HIV/AIDS of similar demographics/culture/location, etc.

HIV-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

HIV-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

HIV-N NUTRITION

OUTCOME: The patient will understand the importance of maintaining optimal nutrition status.

STANDARDS:

1. Explain the role of immunocompetence and the need for hand washing and safe food handling techniques to reduce exposure to infections.
2. Explain the importance of maintaining a balanced nutritious diet. High fat diets can contribute to suppression of immune function.
3. Discuss the benefit of oral supplements in patients with appetite changes, anorexia, or weight loss. Rest periods before and after meals are suggested.
4. Explain the importance of hydration, 9-12 cups/day recommended.
5. Emphasize that herbs and botanical supplements should not be used without discussing with a physician, RD, or pharmacist.
6. Refer to a registered dietician for MNT as appropriate.

HIV-P PREVENTION

OUTCOME: The patient will develop a healthy behavior plan, which will prevent/reduce exposure to HIV infections.

STANDARDS:

1. List circumstances/behaviors that increase the risk of HIV infection:
   a. IV drug use and sharing needles.
   b. Multiple sexual partners.
   c. Unprotected sex, e.g., sex without latex or polyurethane condoms or other protective agents, dental dams, plastic wrap.
   d. Anal intercourse.
   e. Breastfeeding by an HIV infected mother.
   f. Being born to an HIV infected mother.
   g. Presence or history of another sexually transmitted infections.
   h. Victims of rape.
   i. Involvement in a abusive relationship.
2. Describe behavior changes that prevent/reduce transmission of HIV virus.
3. Discuss/demonstrate proper application of condom with model if available. Discuss proper lubricant type. (No oil-based lubricants.)
4. Describe how alcohol/substance use can impair judgment and reduce the ability to use protective measures.
5. Explain ways to reduce exposure to infected persons.
6. Explain that the best way to prevent exposure to HIV is to abstain from risky sexual behavior and from recreational drug use.

HIV-PN PRENATAL

OUTCOME: The patient/family will understand risk factors for HIV (mother and child) and offer referral for testing.

STANDARDS:

1. Discuss the risk factors for HIV (mother and child).
2. Offer referral for HIV testing.
3. Explain that early detection, early treatment and full participation with the medication regimen, as well as, maintaining a healthy lifestyle will often result in a

better quality of life and will slow the progression of the disease and may have beneficial effects upon the delivery and longevity of the child.

HIV-S SAFETY

OUTCOME - The patient/family/caregiver will understand principles of planning and living within a safe environment.

STANDARDS:

1. Explain that opportunistic infections are a major cause of death.
2. Discuss the need to prevent opportunistic infections through creating and living within a safe environment.
3. Assist the patient/family/caregiver in identifying ways to adapt the home to improve safety and prevent injury, illness and disease transmission appropriate to the patient's age, disease state and condition.
4. Identify which community resources promote a safe living environment.

HIV-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in HIV/AIDS.

STANDARDS:

1. Explain that uncontrolled stress can contribute to a suppressed immune response and can increase the complications from HIV/AIDS.
2. Explain that effective stress management may help to reduce the adverse consequences of HIV/AIDS, as well as, improve the patient's health and well-being.
3. Discuss that stress may exacerbate adverse health behaviors, such as increased tobacco, alcohol, or other substance abuse, all which can increase the risk of morbidity and mortality from HIV/AIDS.
4. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. Becoming aware of your own reactions to stress
    b. Recognizing and accepting your limits
    c. Talking with people you trust about your worries or problems
    d. Setting realistic goals
    e. Getting enough sleep
    f. Maintaining a healthy diet
    g. Exercising regularly

h. Taking vacations

i. Practicing meditation. self-hypnosis, and positive imagery

j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation

k. Participating in spiritual or cultural activities

5. Discuss suggestions for dealing with the emotional toll of living with HIV/AIDS:

   a. Learn all you can about HIV/AIDS.

   b. Be proactive, take an active role in your treatment.

   c. Maintain a strong support system.

   d. Take time to make important decisions concerning your future.

   e. Come to terms with your illness.

6. Provide referrals as appropriate.

HIV-TE TESTS

OUTCOME: The patient/family will understand the reason for testing, the expected outcome, and whether the test will be confidential or anonymous.

STANDARDS:

1. Explain that early detection, early treatment, and full participation with the medication regimen, as well as, maintaining a healthy lifestyle will often result in a better quality of life and slower progression of the disease.
2. Explain that identification of all partners is necessary to facilitate the treatment of those persons and limit further spread of the infection.
3. Explain that if you receive a diagnosis of HIV/AIDS, your doctor will use a test to help predict the probable progression of your disease. This test measures the amount of virus in your blood and aids in determining your course of treatment.
4. Emphasize the importance of using only approved test kits for HIV (as of November 2004 is the Home Access HIV test marketed by Home Access Health).

HIV-TX TREATMENT

OUTCOME: The patient/family will understand the importance of a chronic treatment plan,

STANDARDS:

1. Discuss importance and primary causes of treatment failure including uninterrupted access to medical care and adherence to treatment plans.

2. Discuss or identify other barriers to treatment failure
   a. Familial support
   b. Geography
   c. Migratory nature
   d. Sociocultural influence
   e. Stigma and/or discrimination
3. Explain that according to current guidelines, treatment should focus on achieving the maximum suppression of symptoms for as long as possible. This aggressive approach is known as high active antiretroviral therapy (HAART). The aim of HAART is to reduce the amount of virus in your blood to very low levels, although this doesn't mean the virus is gone.
4. Emphasize and discuss the importance of a comprehensive treatment plan, which includes health and risk assessment, common lab tests, disease staging, prophylaxis therapy, immunizations, social and insurance needs, plus follow up.
5. Discuss the process for developing a comprehensive treatment plan.
6. Help the patient/family identify the appropriate resources for developing a comprehensive treatment plan.
7. Explain that identification of all partners is necessary to facilitate the treatment of those persons and limit further spread of the infection.

LIP - Hyperlipidemia/Dyslipidemias

LIP-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of anatomy and physiology as it relates to hyperlipidemia/dyslipidemia.

STANDARDS:

1. Discuss the anatomy/physiology as it relates to hyperlipidemia/dyslipidemia.
2. Discuss the changes that occur in blood vessels and other organs as a result of hyperlipidemia/dyslipidemia as it applies to this patient.
3. Explain that hyperlipidemia/dyslipidemia puts patients at higher risk of potentially debilitating cardiovascular disease including heart attack and stroke.

LIP-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of uncontrolled hyperlipidemia/dyslipidemia.

STANDARDS:

1. Explain that heart attacks may result due to blocked arteries in the heart.
2. Explain that strokes may result due to blocked arteries in the neck or brain.
3. Explain that leg pain and loss of use of legs may result due to blocked arteries in the legs.

LIP-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving optimal health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

LIP-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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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.

LIP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand potential causes of hyperlipidemia/ dyslipidemia and the possible progression to cardiovascular disease.

STANDARDS:

1. Review the causative factors of hyperlipidemia/dyslipidemia (e.g., genetic, DM, thyroid disease, liver disease, kidney disease, drugs) as appropriate to the patient.
2. Explain that lipids are fractionated into HDL (good cholesterol) and LDL (bad cholesterol) and triglycerides.
3. Review the lifestyle factors that may worsen hyperlipidemia/dyslipidemia (e.g., obesity, high saturated fat/carbohydrate intake, lack of regular exercise, stress levels, tobacco use, alcohol intake).
4. Emphasize that hyperlipidemia/dyslipidemias in combination with other risk factors greatly increase the risk of other vascular diseases including heart attacks and strokes.

LIP-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in improving/correcting hyperlipidemia/dyslipidemia and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Discuss obstacles to a personal exercise plan and solutions to those obstacles. Assist the patient in developing a personal exercise plan.
4. Encourage the patient to increase the intensity and duration of the activity as the patient becomes more fit.
5. Refer to community resources as appropriate.

LIP-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care, including labwork.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

LIP-L LITERATURE

OUTCOME: The patient/family will receive literature about hyperlipidemia/ dyslipidemia.

STANDARDS:

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

LIP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adaptations necessary to maintain control of hyperlipidemia/dyslipidemia and develop a realistic plan to accomplish this.

STANDARDS:

1. Emphasize that an important component in the prevention and treatment of hyperlipidemia/dyslipidemia is the patient's adaptation to a healthier, lower risk lifestyle (nutrition, physical activity, tobacco cessation, and stress reduction).
2. Assist the patient to formulate a therapeutic plan which includes stress reduction, diet, exercise, tobacco cessation and medications, as indicated.
3. Review the nationally accepted, current lipid reduction goals and assist the patient to establish a personal goal for lipid control.

LIP-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use and expected outcomes of prescribed drug therapy.

STANDARD:

1. Review the proper use, benefits, and common or important side effects of the prescribed medications.
2. Describe the name, strength, purpose, dosing directions, and storage of the medication.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions (e.g., CYP inhibitors, grapefruit).
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

LIP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family understand the specific nutritional intervention(s) needed for treatment or management of hyperlipidemia/dyslipidemia.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:

a. Assessment of the nutrition related condition.
b. Identification of the patient's nutritional problem.
c. Identification of a specific nutrition intervention therapy plan.
d. Evaluation of the patient's nutritional care outcomes.
e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

LIP-N NUTRITION

OUTCOME: The patient/family will understand the relationship between nutrition and lipid levels.

STANDARDS:

1. Explain the basics of nutrition therapy and weight management for all patients with hyperlipidemia/dyslipidemia.
2. Explain the how carbohydrates and alcohol use can contribute to elevated triglycerides levels.
3. Discuss the importance of decreasing saturated fats and eliminating trans fats in the diet. Encourage reading food labels including how to identify various ingredients on the labels.
4. Discuss benefits of adding soluble fiber (apples, legumes, oat and bran) and omega-3 fatty acids such as fish oils and flax seed to the diet as appropriate.
5. Refer to a registered dietitian for MNT as appropriate.

LIP-P PREVENTION

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

STANDARDS:

1. Explain that consuming a diet low in fat and cholesterol, maintaining a healthy weight, and exercising regularly may help prevent hyperlipidemia/dyslipidemia.
2. Assist the patient/family in developing a plan for hyperlipidemia/dyslipidemia prevention (including regular screening for lipid disorders).

LIP-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in lipid disorders.

STANDARDS:

1. Explain that uncontrolled stress can raise lipids and interfere with the treatment of lipid disorders, increase the severity of coronary artery disease, and decrease overall health and well-being.
2. 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 arterial disease.
3. Explain that effective stress management may help reduce the severity of arterial disease, as well as, help improve the health and well-being of the patient. Discuss examples of various stress management strategies:
   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 healthy diet
   g. Exercising regularly
   h. Taking vacations
   i. Practicing meditation, self-hypnosis, and positive imagery
   j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   k. Participating in spiritual or cultural activities
4. Provide referrals as appropriate.

LIP-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 necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.

2. Explain any necessary preparation and instructions for the test (e.g., fasting).
3. Discuss the patient's goals of therapy and the meaning of the test results, as appropriate.

LIP-TX TREATMENT

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

STANDARDS:

1. Discuss that different medications/therapies are used for different forms of hyperlipidemia/dyslipidemia and that development of a treatment plan will involve the patient and the medical team.
2. Discuss the treatment plan including pharmacologic therapy, nutrition, exercise 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.

HTN - Hypertension

HTN-C COMPLICATIONS

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

STANDARDS:

1. Explain that hypertension reduces oxygen delivery to major body organs.
2. Explain that heart attacks may result from the heart having to work harder to pump blood through congested and hardened arteries.
3. Explain that blindness may result from injured blood vessels in the eye.
4. Explain that strokes may result from ruptures of injured blood vessels in the brain.
5. Explain that circulatory complications eventually impair the ability of the kidneys to filter out toxins.

HTN-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

HTN-DP DISEASE PROCESS

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

STANDARDS:

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

HTN-EQ EQUIPMENT

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

STANDARDS:

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

HTN-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.

3. Discuss obstacles to a personal exercise plan and solutions to those obstacles. Assist the patient in developing a personal exercise plan.
4. Encourage the patient to increase the intensity and duration of the activity as the patient becomes more fit.
5. Refer to community resources as appropriate.

HTN-FU FOLLOW-UP

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

STANDARDS:

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

HTN-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive literature about hypertension.

STANDARDS:

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

HTN-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

HTN-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the benefits and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food and alcohol interactions, as appropriate.
4. As appropriate, explain that hypertension is caused by multiple mechanisms and more than one medication may be required to lower blood pressure to the patient's personal goals.
5. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

HTN-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of hypertension.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
    a. Assessment of the nutrition related condition.
    b. Identification of the patient's nutritional problem.
    c. Identification of a specific nutrition intervention therapy plan.
    d. Evaluation of the patient's nutritional care outcomes.
    e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

HTN-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition in managing hypertension.

STANDARDS:

1. Explain the role of salt intake in hypertension. Methods to decrease salt intake are by removing the salt shaker from the table, tasting food before salting, reading food labels, using other seasonings to flavor foods.
2. Explain that the use of herbs and supplements and salt substitutes that contain potassium may be contraindicated with other medications.
3. Discuss caffeine and alcohol in hypertension.
4. Encourage adequate intake of fruits, vegetables, water, and fiber.
5. Discuss the importance of weight loss and exercise in controlling hypertension**.** **Refer to "HPDP-N Nutrition" on page 483.**

HTN-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress can worsen hypertension and increase risk factors of cardiovascular disease.
2. Explain that uncontrolled stress can interfere with the treatment of hypertension.
3. Explain that effective stress management may reduce the adverse consequences of hypertension, as well as help improve the health and well-being of the patient.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality from hypertension.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
   a. Becoming aware of your own reactions to stress
   b. Recognizing and accepting your limits
   c. Talking with people you trust about your worries or problems
   d. Setting realistic goals
   e. Getting enough sleep
   f. Maintaining a healthy diet

g. Exercising regularly

h. Taking vacations

i. Practicing meditation, self-hypnosis, and positive imagery

j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation

k. Participating in spiritual or cultural activities

6. Provide referrals as appropriate.

HTN-TE TESTS

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

STANDARDS:

1. Explain the test ordered and collection method.
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 and instructions for the test ordered.
5. Explain the meaning of the test results, as appropriate.

HTH - Hyperthyroidism

HTH-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the anatomy and physiology of the pituitary-thyroid axis.

STANDARDS:

1. Explain the normal location, function, and feedback mechanism of the pituitary-thyroid axis (heart rate, muscle strength, bowel function, fat metabolism, energy level, hair growth, and mood).
2. Discuss the changes to the thyroid gland and the body's metabolic state as a result of hypothyroidism.
3. Discuss the impact of these changes on the patient's health and well-being.

HTH-C COMPLICATIONS

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

STANDARDS:

1. Discuss the significant complications associated with hyperthyroidism (atrial fibrillation, heart failure, angina, myocardial infarction, osteoporosis, depression, personality changes, proptosis).
2. Explain that taking medications as prescribed may prevent most or all significant complications.
3. Discuss common or significant complications which may result from treatment, e.g., subsequent hypothyroidism and the need to take lifelong medication.

HTH-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology of hyperthyroidism.

STANDARDS:

1. Explain that hyperthyroidism occurs when the amount of thyroid hormone in the blood is too high. It affects over 2½ million Americans. More women have this problem than men.
2. Explain that hyperthyroidism leads to an overall increase in a person's metabolism, which can cause a number of problems.

3. Review the patient-specific cause and expected course of hyperthyroidism, e.g., "increased production" due to hypersecretory state (e.g., Grave's disease, toxic nodule, toxic multinodular goiter, or overproduction of TSH from pituitary), "leakage" of stored hormone due to thyroid damage (as in thyroiditis), or too much supplement.
4. Review the symptoms of hyperthyroidism:
   a. Feelings of excessive warmth and sweating
   b. Palpitations
   c. Tremors
   d. Weight loss despite having an increased appetite
   e. More frequent bowel movements
   f. Weakness
   g. Limited endurance
   h. Difficulty concentrating
   i. Memory impairment
   j. Nervousness
   k. Tiredness
   l. Difficulty sleeping
   m. Depression
   n. Personality changes
   o. Enlarged thyroid—usually nontender

HTH-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up (both symptoms of hyperthyroidism and hypothyroidism).

5. Discuss the availability of community resources and support services and refer as appropriate.

HTH-L LITERATURE

OUTCOME: The patient/family will receive literature about hyperthyroidism.

STANDARDS:

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

HTH-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the benefits and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food and alcohol interactions, as appropriate.
4. As appropriate, explain the implications that medications have on current or potential pregnancy.
5. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

HTH-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of hyperthyroidism.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.

c. Identification of a specific nutrition intervention therapy plan.
d. Evaluation of the patient's nutritional care outcomes.
e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

HTH-N NUTRITION

OUTCOME: The patient/family will understand the importance of adequate nutrition to promote healing.

STANDARDS:

1. Discuss the relationship between making healthy food choices and the healing process.
2. Refer to a registered dietician for MNT as appropriate.

HTH-SCR SCREENING

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

STANDARDS

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

HTH-TE TESTS

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

STANDARDS:

1. Explain the test ordered and collection method (e.g., TSH, T3, T4, nuclear scan, ultrasound).

2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment. Discuss the risks of non-performance of the testing.

HTH-TX TREATMENT

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

STANDARDS:

1. List the patient-specific possible therapies that might be utilized to treat hyperthyroidism (beta-blocker, anti-thyroid drugs, radioactive iodine, surgery).
2. Briefly explain each of the possible applicable treatments.
3. Explain that the patient and medical team will make the treatment decision after reviewing the results of diagnostic tests.
4. Explain the implications that treatment would have on current or potential pregnancy.

HPTH - Hypothermia

HPTH-C COMPLICATIONS

OUTCOME: The patient/family will understand the common or serious complications of hypothermia.

STANDARDS:

1. Explain that the 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 the common and important complications of hypothermia, e.g., arrhythmias, dehydration, hyperkalemia, hyperglycemia, hypoglycemia, altered arterial blood gasses, infection, gangrene, amputation, coma, and frostbite. **Refer to "FRST - Frostbite" on page 414**.
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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in the medical plan.
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 healthcare 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 treatment of hypothermia.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

HPTH-L LITERATURE

OUTCOME: The parent(s) and family will receive literature about hypothermia and important preventative measures.

STANDARDS:

1. Provide the patient and/or family with literature on hypothermia.
2. Discuss the content of the literature.

HPTH-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.

4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

HPTH-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of hypothermia.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

HPTH-N NUTRITION

OUTCOME: The patient/family will understand the importance of adequate nutrition to promote healing.

STANDARDS:

1. Review the relationship between making healthy food choices and the healing process.
2. Refer to a registered dietician for MNT as appropriate.

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. Staying dry as much as possible
   d. Keeping an emergency supply kit in the car that 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 - Pain Management" on page 657.**
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. Doing regular physical activity
    h. Taking vacations
    i. Practicing meditation, self-hypnosis, and positive imagery
    j. Practicing relaxation methods such as deep breathing or progressive muscular relaxation
    k. Participating in 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 and collection method (X-Ray, EKG, urine, blood, ABGs).
2. Explain any necessary preparation and instructions 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 (e.g., 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.

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/caregiver 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. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Assist the patient in developing a personal exercise plan. Explain that exercise should be consistent and of sufficient duration to obtain the desired outcome.
4. Encourage the patient to increase the intensity of the activity as the patient becomes more fit.
5. 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.

6. Refer to community resources as appropriate.

LTH-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up (both symptoms of hyperthyroidism and hypothyroidism).
5. Discuss the availability of community resources and support services and refer as appropriate.

LTH-L LITERATURE

OUTCOME: The patient/family will receive literature about hypothyroidism.

STANDARDS:

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

LTH-LA LIFESTYLE ADAPTATIONS

OUTCOME: 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 purpose, proper use and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the benefits and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food and alcohol interactions, as appropriate.
4. As appropriate, explain the implications that medications have on current or potential pregnancy.
5. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

LTH-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of hypothyroidism.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

LTH-N NUTRITION

OUTCOME: The patient/family will understand the nutritional needs of the patient with hypothyroidism.

STANDARDS:

1. Review normal nutritional needs for optimal health.
2. Discuss the need for the correct combination of nutrients and vitamins, as well as the need for a low-fat diet.
3. Explain that the following foods may increase the risk of developing a goiter and must be limited: cabbage, Brussels sprouts, kale, cauliflower, asparagus, broccoli, soy beans, lettuce, peas, spinach, turnip greens and watercress.
4. Encourage the use of iodized salt if indicated and adequate fluid intake.
5. Explain that the long term use of soy protein products may be contraindicated. Refer to a registered dietician for MNT.

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 and collection method, e.g., 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 and/or family will understand the importance of follow-up for immunizations.

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: The 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 LITERATURE

OUTCOME: The patient/family will receive literature n about immunizations.

STANDARDS:

1. Provide the patient/family with literature on immunizations.
2. Discuss the content of the literature.
3. Common sources of patient information for immunizations are Vaccine Information Sheets (required with each immunization administration). These can be found at: http://www.cdc.gov/nip/publications/VIS/default.htm

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.

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. Disease 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 and/or family will understand the importance of follow-up in the treatment of impetigo.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

IMP-L LITERATURE

OUTCOME: The patient/family will receive literature about impetigo.

STANDARDS:

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

IMP-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the benefits and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food and alcohol interactions, as appropriate.
4. Explain the importance of completing the full course of antibiotic therapy to prevent antibiotic resistance and to facilitate complete recovery.

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 "HPDP-HY Hygiene" on page 481**.

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, e.g., increasing redness, soreness, high fever.

FLU - Influenza

FLU-AVN AVIAN FLU

OUTCOME: The patient/family will understand special circumstances about avian flu.

STANDARDS:

1. Discuss with the patient/family the risks associated with avian flu.
2. Explain the transmission of avian flu.
3. Discuss the treatment options for avian flu.
4. Discuss the risk of consuming domestic or wild fowl.
5. Emphasize that extreme caution should be used when handling dead carcasses of potentially ill fowl.
6. Discuss that avian flu can be transmitted to humans from body excretions (such as saliva, nasal secretions, and feces) of infected birds. Discuss that behaviors that carry an especially high risk of infection include the slaughtering, defeathering, butchering, and preparation for consumption of diseased poultry.

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's 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 in the treatment of influenza.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

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 LITERATURE

OUTCOME: The patient/family will receive literature about influenza.

STANDARDS:

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

FLU-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use and expected outcomes of prescribed drug therapy. (Discuss any or all of the following as appropriate.)

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication. Include treatment of symptoms with OTC medications.
2. Discuss the risks, benefits and common or important side effects of the medication and follow up as appropriate.
3. Discuss the use of antiviral treatment for influenza and that therapy must be started within 48 hours. Antiviral therapy will not eliminate flu symptoms, but it may help shorten the course of the illness. It is important to complete the full course of antiviral therapy.
4. Discuss any significant drug/drug, drug/food and alcohol interactions, as appropriate.
5. 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.

6. If appropriate, 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.
7. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

FLU-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for influenza.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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. One effective strategy is to take 5 to 15 cc's of clear fluid every 5 to 10 minutes until 8 hours have passed without vomiting.

FLU-P PREVENTION

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 a high calorie/high protein intake should be encouraged. Small frequent meals, snacks, and fluids may be better tolerated.
4. Discuss that vomiting may be present: 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. One effective strategy is to take 5 to 15 cc's of clear fluid every 5 to 10 minutes until 8 hours have passed without vomiting.

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, e.g., 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 or at home.
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/caregiver 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. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Assist the patient in developing a personal exercise plan. Explain that exercise should be consistent and of sufficient duration to obtain the desired outcome.

4. Encourage the patient to increase the intensity of the activity as the patient becomes more fit.
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Refer to community resources as appropriate.

INJ-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

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, e.g., 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 LITERATURE

OUTCOME: The patient/family will receive literature about the specific injury.

STANDARDS:

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

INJ-M MEDICATION

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

INJ-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of the injuries.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.

e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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 "HPDP-S Safety and Injury Prevention" on page 483.**

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 - Pain Management" on page 657.**
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 and collection method.

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 and instructions 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, e.g., 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 and/or family will understand the importance of 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 literature about the laboratory procedure.

STANDARDS:

1. Provide patient/family with literature on the laboratory procedure.
2. Discuss the content of the literature.

LAB-S SAFETY

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

STANDARDS:

1. Discuss the use of personal protective equipment (e.g., 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 and collection method.
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 and instructions for the test, e.g., 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, e.g., 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, e.g., 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 and/or family will understand the importance of follow-up in the treatment of lead exposure and lead toxicity.

STANDARDS:

1. Discuss the importance of follow-up care, including the importance of assessing the effectiveness of treatment and correcting problems that may develop.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

PB-L LITERATURE

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

STANDARDS:

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

PB-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of lead toxicity.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
    a. Assessment of the nutrition related condition.
    b. Identification of the patient's nutritional problem.
    c. Identification of a specific nutrition intervention therapy plan.
    d. Evaluation of the patient's nutritional care outcomes.
    e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.

3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PB-N NUTRITION

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

STANDARDS:

1. Discuss that the nutritional status of the individual impacts the amount of lead that is absorbed, e.g., 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 for MNT 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 Nutrition" on page 567**.
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 that 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 CDCs 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 one 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 TREATMENT

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

STANDARDS:

1. Discuss the blood lead level that would require chelation therapy and how this relates to this patient and current blood lead level.
2. Discuss as appropriate that children with blood lead level 45Fg/dl are often candidates for chelation therapy.
3. **Refer to "PB-TE Tests" on page 569.**
4. Explain that chelation therapy for persons with lead encephalopathy can be life-saving.
5. Discuss as appropriate that chelation for persons without lead encephalopathy may prevent symptom progression and further toxicity.
6. Discuss the agent to be used for chelation in persons who are to undergo chelation. Discuss the risks and benefits of treatment.
7. Explain that the treatment decision will be made by the patient and medical team after reviewing the results of diagnostic tests.

LIV - Liver Disease

LIV-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family/caregiver will understand the process of developing an advance directive and its role in maintaining a sense of control in the patient's medical care and decisions.

STANDARDS:

1. Explain that patients may lose the ability to make their own decisions and an advance directive will be able to express the patient's desires prior to the loss of decision-making abilities.
2. Review the option of Advanced Directives/Living Will with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
3. Refer to appropriate services to assist the patient in making a living will, e.g., Social Services, Clergy, Lawyer.
4. **Refer to "ADV - Advance Directives" on page 40.**

LIV-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The Patient/Family will have a basic understanding of where the liver is located in the body and its function.

STANDARDS:

1. Explain that the liver is the largest organ in the abdominal cavity. It is a vital organ responsible for storing, converting, and synthesizing essential nutrients in conjunction to detoxifying drugs and producing clotting factors.
2. Explain that life style practices such as alcohol/substance abuse or exposure to certain toxic materials or viral infections can damage the liver.
3. Explain that the liver has some capacity to regenerate or repair. This ability is inhibited or eliminated by continuous exposure to toxic substances such as alcohol, drugs, infections and other unknown factors.
4. Explain that alcohol and many other foreign substances must be detoxified by the liver in order for the substance to be eliminated from the body.

LIV-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of untreated or progressive liver disease (discuss standards that apply to patient's disease process).

STANDARDS:

1. Explain that Ascites, defined as a pathological fluid in the peritoneal cavity, is often seen in patients with hepatic cirrhosis. Review current findings regarding prognosis for patients with Ascites may be poor if not properly managed.
2. Explain that jaundice is a build up of bile acids and bilirubin. It is a yellowish discoloration of the skin, mucus membranes, and some body fluids maybe a sign of a cirrhotic liver.
3. Explain that end stage liver disease may have as a complication intense uncontrollable pruritis.
4. Explain that a common complication of liver disease is esophageal varices. Rupture of one of these varices is a life-threatening complication of liver disease.
5. Discuss that liver disease has a profound impact on clotting factors and may result in uncontrollable bleeding or abnormal clotting which can result in end organ damage of any part of the body.
6. Explain that another common end stage complication of liver disease is encephalopathy which may lead to a comatose state and death.
7. Explain that obesity can contribute to a fatty liver.

LIV-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, e.g., diet, exercise, sleep, stress management, hygiene, full participation in the medical plan.
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 healthcare provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges, may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.

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

LIV-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the specific liver disease. (Discuss the standards that pertain to this patient's liver disease.)

STANDARDS:

1. Explain that cirrhosis is caused by chronic degeneration of the parenchymal liver cells and thickening of the surrounding tissue.
2. Explain that alcohol and some drugs alter both the activation and degradation of key nutrients thereby compromising the overall function of the body.
3. Explain that cryptogenic cirrhosis is caused by unknown etiology.
4. Explain that certain viral infections such as hepatitis may result in destruction of liver cells, cirrhosis or hepatic cancer.
5. Explain that medications and over-the-counter medications and supplements can cause liver damage or liver failure. Larger than recommended dosages of acetaminophen (Tylenol®) can result in irreversible liver damage and death. This effect may be amplified by concurrent use of alcohol.

LIV-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the patient's responsibility in the management of the disease process.
2. Discuss the importance of limiting substances that are toxic to the liver.
3. Emphasize the importance of following the treatment plan even if the patient is asymptotic.
4. Discuss the procedure for obtaining follow-up appointments.
5. Emphasize the importance of keeping follow up appointments.

LIV-L LITERATURE

OUTCOME: The patient/family will receive literature about liver disease.

STANDARDS:

1. Provide the parent/family with literature on liver disease.
2. Discuss the content of the literature.

LIV-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will collaborate to make the lifestyle adaptations necessary to minimize complications and improve overall health.

STANDARDS:

1. Review lifestyle/changes that the patient can control such as diet, exercise, medication regimen, safety and injury prevention, avoidance of high risk behaviors and full participation with the treatment plan.
2. Emphasis the importance of the patient's adaptation to a healthier and lower risk lifestyle in order to minimize the complications of liver disease.
3. Review the community resources available to assist the patient in making lifestyle changes and make referrals as needed.

LIV-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

LIV-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of liver disease.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

LIV-N NUTRITION

OUTCOME: The patient/family will understand the diet regimen pertaining to liver disease.

STANDARDS:

1. Explain that the appropriate dietary regimen is one of the essential components in the management of liver disease, such as reducing sodium aids with diuresis.
2. Explain that fluid restrictions may be necessary to reduce fluid retention due to portal hypertension. Large meals increase portal pressure. Encourage smaller meals more frequently.
3. Explain that milk and eggs produce less ammonia that meats as appropriate.
4. Explain that herbs and supplements should not be used without discussing with the physician.
5. Explain that the patient should meet regularly with a Registered Dietitian for ongoing medical nutrition therapy.

LIV-TE TESTS

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

STANDARDS:

1. Explain the test ordered and collection method.

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 and instructions for the test.
5. Explain the meaning of the test results, as appropriate.

LIV-TX TREATMENT

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

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options. Discuss the risks and benefits of treatment as well as the possible consequences of refusing treatment.
2. Discuss the treatment plan including lifestyle adaptations, pharmacologic, surgical, and psychosocial aspects of the treatment plan.
3. Discuss the importance of adhering to the treatment plan, emphasizing the importance of full participation even if the patient is asymptomatic.
4. Emphasize the importance of keeping scheduled follow-up appointments.
5. Refer to community resources as appropriate.

M

MSAF - Medical Safety

(to reduce confusion with M)

MSAF-C COMPLICATIONS

OUTCOME: The patient and/or family will understand the importance of preventing and managing medical errors.

STANDARDS:

1. Discuss with patients/family members that it is important for them to take an active role in their healthcare.
2. Discuss with the patient/family how to contact the appropriate healthcare provider with questions regarding medical therapy or potential medical errors.
3. Discuss with the patient/family when it is appropriate to go to the emergency room if a medical error, medication side-effect, or other emergency situation occurs as a result of medical treatments.

MSAF-FU FOLLOW-UP

OUTCOME: The patient and/or family will understand the importance of follow-up for medical safety.

STANDARDS:

1. Discuss the importance of maintaining follow-up appointments to minimize the risk of medical errors.
2. Discuss the importance of reviewing follow-up information such as laboratory results and other test results.

MSAF-I INFORMATION

OUTCOME: The patient/family will be able to identify their primary provider and the condition(s) for which the patient is being treated.

STANDARDS:

1. Emphasize the importance of knowing the identity of the physician in charge of the total care.

2. Assist the patient/family in identifying their primary physician.
3. Discuss the conditions for which the patient is being treated and methods of treatment being used as well as options available.
4. Refer to reliable resources for more information as appropriate.

MSAF-L LITERATURE

OUTCOME: The patient/family will receive literature about medical safety.

STANDARDS:

1. Provide parent/family with literature on medical safety.
2. Discuss the content of the literature.

MSAF-M MEDICATIONS

OUTCOME: The patient/family will understand that medications are a potential source for medical errors.

STANDARDS:

1. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation and interaction review.
2. Discuss the importance of informing your providers of any allergies or adverse medication reactions that you may have experienced.
3. Discuss the importance of being able to identify medications by the name, strength, purpose, and dosing directions.
4. Discuss the storage of the medication, including the use of safety caps and non-safety caps, and keeping medicine and pill boxes out of reach of children.
5. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
6. Instruct the patient to check the medication labels each time medicine is filled to verify the patient's name on the medication and that medication labels are easily understood.
7. Discuss the importance of being able to take the appropriate amount of medication. Ensure dosage forms can be obtained (e.g., breaking tablets in half or using a pill cutter) and that appropriate measuring devices (e.g., pill boxes, oral syringes, droppers) are provided and instruction on their use given.

MSAF-P PREVENTION

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

STANDARDS:

1. Discuss the types of medical errors:
   a. Medicine
   b. Surgery
   c. Diagnosis
   d. Equipment
   e. Lab reports
2. Explain that medical errors can occur anywhere in the healthcare system including the hospital, clinic, outpatient surgery center, doctor's office, nursing home, pharmacy, patient's home, and referral services.
3. Discuss with patients/family members that it is important for them to take an active role in their healthcare.
4. Discuss the importance of knowing who the patient may contact for medical advice and information.
5. Discuss the importance of all healthcare workers being aware of your health and care and having your medical record available.
6. Instruct patient that if necessary, a family member or friend may accompany them to their appointment.
7. Explain that when possible, you should select a hospital that has experience in the procedures that you need.
8. Emphasize the importance of proper hand washing in the prevention of disease transmission. Encourage the patient to ask the healthcare worker about hand washing if there are any concerns.

MSAF-TE TESTS

OUTCOME: The patient/family will understand the importance of knowing what test(s) will be performed, why they will be performed, and how to obtain the results.

STANDARDS:

1. Explain the specific test ordered and collection method. Emphasize the importance of knowing what tests will be done and why they will be done.
2. Explain to the patient how to obtain test results if they have not been provided.

M - Medications

M-DI DRUG INTERACTION

OUTCOME: The patient/family will have an awareness of potential drug, food, or alcohol interactions associated with the prescribed medications.

STANDARDS:

1. Explain the potentially serious adverse effects of the specific interactions with other drugs (including OTC medications and traditional or herbal medicines).
2. Specifically discuss adverse effects of this medication when combined with specific foods.
3. Emphasize the importance of informing the provider (e.g., physician, pharmacist, nurse) of any drug interaction(s) that have occurred in the past.
4. Inform the patient of the procedure to follow in the event of a drug interaction.

M-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of follow-up in the medication treatment plan.

STANDARDS:

1. Discuss the individual's responsibility in the management of medication therapy.
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. Discuss the importance of informing all healthcare providers of medications taken, including prescription, over-the-counter, herbal, supplements, and traditional medicine (medication reconciliation).
4. Discuss the importance of follow up of medication therapy to assess adverse drug effects, safety, and efficacy of the prescribed medications.
5. Assist the patient in obtaining a follow-up appointment as necessary.

M-I INFORMATION

OUTCOME: The patient/family will demonstrate knowledge of the use and benefits of the medications in the treatment plan.

STANDARDS:

1. Give the name of the drug and show the drug to patient where applicable.

2. Briefly review the mechanism of action of the drug and the reason for taking it.
3. Review the directions for use and duration of therapy.
4. Discuss the probable benefits of therapy.
5. Discuss the importance of full participation with medication regimen.
6. Review the probable side-effects and toxicities of medication. Review the course of action to take if toxicity occurs.
7. Emphasize the importance of informing the provider prior to initiating any new medications.
8. Discuss the proper storage and handling of medications.

M-L LITERATURE

OUTCOME: Patient/family will receive literature about the medication(s) prescribed.

STANDARDS:

1. Provide patient/family with literature about the prescribed medication(s).
2. Discuss the content of the literature.

M-MB MEDICATION BOX TEACHING

OUTCOME: The patient/family will be able to fill and use a medication box correctly.

STANDARDS:

1. Explain the benefits of using medication boxes.
2. Demonstrate to the patient/family how to fill the box while verbalizing the thought processes involved.
3. Discuss the importance of reading medication labels carefully.
4. Discuss non-child resistant boxes and proper storage as appropriate.
5. Instruct the patient/family on mechanisms to overcome barriers to proper use of medication boxes.
6. Demonstrate and participate in return demonstration of opening and filling the medication box and showing the provider the correct slot for next dosage time.

M-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.

M-NEB NEBULIZER

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

STANDARDS:

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

M-PRX MEDICATION DISPENSATION TO PROXY

OUTCOME: The person to whom the medication is dispensed will understand information about the medication and will develop a plan to assure proper medication use.

PROXY – Defined as a person who is picking up the patient's medications when: (a) the patient is not present and (b) the proxy was not present during the patient visit. If the patient or family member is picking up the medication, or if the person picking up the medication was present during the patient's visit (e.g., family member), use the M-I code.

STANDARDS:

1. The proxy will receive information on proper administration of the medications dispensed.
2. The proxy will understand that they are responsible for conveying the education to the patient when picking up the patient's medications.
3. The proxy will understand the responsibility for delivering the patient's medications. The pharmacy is no longer responsible for the medications once they leave the pharmacy.

MPS - Menopause

MPS-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the anatomy and physiology of the female reproductive system and the changes associated with menopause.

STANDARDS:

1. Explain the normal anatomy and physiology of the female reproductive system.
2. Explain that hormones produced by the ovaries have wide ranging effects that involve not only the uterus and ovaries but also the brain, skin, blood vessels, heart, bones, breasts, and the urinary system.
3. Explain that menopause is a normal part of life and involves changes in levels of many hormones as well as physical and emotional changes.

MPS-C COMPLICATIONS

OUTCOME: The patient/family will understand some of the potential changes associated with menopause.

STANDARDS:

1. Discuss the changes that may occur with menopause and the impact of these changes on the patient's health. Explain how complications/symptoms of menopause are related to decreased estrogen and other hormones.
    a. Loss of bone density leading to osteoporosis may include oral cavity changes
    b. Increased cardiovascular risks
    c. Loss of fertility
    d. Vasomotor symptoms, hot flashes
    e. Mood changes (irritability, anxiety, mood swings, depression, agitation, changes in libido) and sleep disturbances
    f. Urogenital symptoms: atrophy, thinning, dryness, vulvar itching/irritation, loss of vaginal elasticity, pain/discomfort with sexual activity, frequent urination, urinary urgency, stress incontinence, pelvic relaxation
    g. Mild concentration and memory impairment
    h. Ocular changes (dryness, burning, pressure, sensitivity to light, blurred vision, increased lacrimation)
    i. Weight gain, palpitations, skin changes, joint pain, and headache

j. Hair changes

MPS-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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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.

MPS-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the changes that may occur with menopause.

STANDARDS:

1. Discuss menopause as the end of menstruation and fertility usually defined by no menstruation for 12 months. Explain that menopause may be caused by medical interventions, such as surgery, chemotherapy, or pelvic radiation but more commonly menopause occurs as a result of a normal developmental process.
2. Explain that in the United States menopause typically occurs between 45–55 years of age but may occur earlier or later. The whole process may take several months or years.
3. Discuss common manifestations of menopause:

a. Vasomotor: hotflashes may include irritability, anxiety, sleeplessness, and agitation

b. Urogenital: atrophy, thinning, dryness, and loss of elasticity

4. Discuss the different classifications of menopause:
   a. Age 45–55 with hot flashes and irregular menses assume perimenopausal
   b. Age 45–55 with hot flashes and no menses for 6 months assume menopausal
   c. Age < 45 with hot flashes but regular menses or irregular menses but no hot flashes could be early menopause further investigation may be indicated
   d. Age 40–50 Menopausal symptoms still on oral contraceptives possibly menopause further investigation may be indicated
5. Discuss how menopause relates to altered hormone production. As appropriate discuss the current understanding of medications/herbals/etc. in the treatment of menopausal changes.

MPS-EX EXERCISE

OUTCOME: The patient/family will understand the relationship between exercise and the changes of menopause and will develop a plan to achieve an appropriate activity level.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Discuss obstacles to a personal exercise plan and solutions to those obstacles. Assist the patient in developing a personal exercise plan.
4. Encourage the patient to increase the intensity and duration of the activity as the patient becomes more fit.
5. Refer to community resources as appropriate.

MPS-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care, including the importance of correcting problems that may develop.

2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

MPS-L LITERATURE

OUTCOME: The patient/family will receive literature about menopause.

STANDARDS:

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

MPS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand that certain behaviors reduce the risk of complications that may be associated with menopausal changes.

STANDARDS:

1. Discuss behaviors which promote good health and reduce the risk of potential complications associated with menopausal changes, e.g., osteoporosis and cardiovascular disease including:
   a. Avoidance of tobacco, excessive caffeine, and other drugs of abuse
   b. Regular weight bearing exercise to reduce the risk of osteoporosis and regular aerobic exercise to reduce the risk of cardiovascular disease
   c. Stress reduction
   d. Balanced diet low in fat and rich in calcium and Vitamin D
   e. Maintenance of a healthy weight
2. Advise the patient of potential triggers for hot flashes and avoidance of triggers:
   a. Stress and anxiety
   b. Spicy foods
   c. Caffeine
   d. Hot drinks
   e. Alcoholic beverages

f. Hot environment

3. Discuss the current recommendations for breast exams including mammography. Refer the patient to a physician for the most current information.

MPS-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

MPS-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for the management of menopause.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

MPS-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition and menopause.

STANDARDS:

1. Discuss the changes of menopause that may be addressed by dietary modifications such as weight gain, cardiovascular changes, and decreased bone density.
2. Discuss the appropriate caloric intake in response to metabolic changes associated with aging, and the importance to maintaining adequate intake of calcium and vitamin D in the diet and/or supplementation as needed.
3. Refer to a registered dietician, physician, or pharmacist as appropriate to discuss other dietary modifications or supplements/herbals.

MPS-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure, including indications, complications, and alternatives, as well as, possible results of not having the procedure performed.

STANDARDS:

1. Discuss the indications, risks, and benefits for the proposed procedures such as pap smears, mammograms, and endometrial monitoring (transvaginal ultrasound, endometrial biopsy).
2. Explain the process and what to expect before, during, and after the procedure.
3. Discuss pain management, as appropriate.
4. Emphasize the importance of fully participating in post-procedure recommendations and follow-up.
5. Discuss procedure findings and implications as appropriate.

MPS-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand principles of injury prevention associated with osteoporosis.

STANDARDS:

1. Discuss ways to reduce risk of falls. Adapt home safety to prevent injury including removing throw rugs, installing bars in the tubs and showers, securing electrical cords. **Refer to "OS - Osteoporosis" on page 639** and **"FALL - Fall Prevention" on page 384.**

2. Identify community resources that promote safety and injury prevention.
3. Provide information regarding key concepts for emergencies.

MPS-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in menopausal symptoms.

STANDARDS:

1. Explain that uncontrolled stress may cause increased symptoms of menopause.
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 compromise overall health.
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 healthy diet
   g. Exercising regularly
   h. Taking vacations
   i. Practicing meditation, self-hypnosis, and positive imagery
   j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   k. Participating in spiritual or cultural activities
5. Provide referrals as appropriate.

MPS-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 collection method.

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 and instructions for the test.
5. Explain the meaning of the test results, as appropriate.

MH - Men's Health

MH-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the male breast, reproductive system and genitalia.

STANDARDS:

1. Explain the normal anatomy and physiology of the breast. Discuss the areola, nipple, ducts, and glands.
2. Explain the normal anatomy and physiology of the male reproductive system. Identify the functions of the testes, prostate, and penis.
3. Explain the normal anatomy and physiology of the male genitalia. Identify the penis, foreskin, scrotum, and perineal area.

MH-BE BREAST EXAM

OUTCOME: The patient/family will understand the importance of breast self-exam and clinical breast exam on physicals.

STANDARDS:

1. Discuss breast anatomy and that cancer can occur in males as well as in females.
2. Emphasize the importance of examination for early detection of breast cancer.
3. Explain that survival rates are markedly higher when cancer is detected and treated early.
4. Teach breast self-exam. Participate in return demonstration.
5. Discuss the importance of routine annual clinical examination.

MH-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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in the medical plan.
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 healthcare 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.

MH-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in men's health.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

MH-HY HYGIENE

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

STANDARDS:

1. Review aspects of good hygiene such as regular bathing, paying special attention to penis and glands.
2. **Refer to "HPDP-HY Hygiene" on page 481**.

MH-L LITERATURE

OUTCOME: The patient/family will receive literature about men's health issues.

STANDARDS:

1. Provide the patient/family with literature on men's health issues.
2. Discuss the content of the literature.

MH-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

MH-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of men's health.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

MH-N NUTRITION

OUTCOME: The patient will understand the role of nutrition and men's health.

STANDARDS:

1. Review normal nutritional needs for optimal health. Discuss food choices when eating away from home.
2. Explain the benefits of a healthy weight and exercise in preventing or delaying the onset of medical problems.
3. Discourage intake of more than two alcoholic drinks per day and encourage adequate water intake.
4. Refer to a registered dietitian for MNT as appropriate.

MH-PRS PROSTATE HEALTH

OUTCOME: The patient will understand the importance of prostate health and cancer prevention.

STANDARDS:

1. Discuss the prostate and the normal changes that occur with age.
2. Discuss the prostate exam and emphasize the importance of examination in early detection of prostate cancer. Explain that survival rates are markedly higher when cancer is detected and treated early.
3. Explain that patients who have first-degree relatives with prostate cancer are at significantly higher risk for cancer.
4. Emphasize the importance of follow-up exams.
5. Discuss the role of prostate-specific antigen testing in the early detection of prostate cancer.

MH-RS REPRODUCTIVE SYSTEM

OUTCOME: The patient will understand the male reproductive system.

STANDARDS:

1. Review the reproductive anatomy and physiology of the male reproductive system.
2. Discuss pathways for sperm during ejaculation.
3. Discuss the importance of good hygiene. Discuss circumcision as appropriate.
4. Discuss prevention and treatment of sexually transmitted infections. **Refer to "STI - Sexually Transmitted Infections" on page 786**.

MH-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in overall health and well-being.

STANDARDS:

1. Explain that uncontrolled stress may cause release of stress hormones that interfere with general health and well-being.
2. Explain that effective stress management may help prevent progression of many disease states, 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 as well as overeating, all of which can increase the risk of morbidity and mortality from many disease states.
4. Emphasize the importance of seeking professional help as needed to reduce stress.
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 healthy diet
   g. Exercising regularly
   h. Taking vacations
   i. Practicing meditation, self-hypnosis, and positive imagery
   j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   k. Participating in spiritual or cultural activities
6. Provide referrals as appropriate.

MH-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, preparation for the test, and method of collection, as applicable.
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 the meaning of the test results, as appropriate.

MH-TSE TESTICULAR SELF-EXAM

OUTCOME: The patient will understand the importance of routine testicular self exam.

STANDARDS:

1. Explain that the purpose of the TSE is to screen for abnormal signs and symptoms of the testes.
2. Emphasize the importance of routine two-step basic TSE. Encourage patients to associate the TSE routine with an important monthly date.

MSX - 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 glucose 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-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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, 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 that 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

OUTCOME: The patient will understand the relationship of exercise to normal lipids, blood pressure, and blood glucose. The patient will develop a physical activity plan.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Discuss obstacles to a personal exercise plan and solutions to those obstacles. Assist the patient in developing a personal exercise plan.
4. Encourage the patient to increase the intensity and duration of the activity as the patient becomes more fit.
5. Refer to community resources as appropriate.

MSX-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.

4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

MSX-L LITERATURE

OUTCOME: The patient will receive literature about metabolic syndrome.

STANDARDS:

1. Provide the patient with literature on metabolic syndrome.
2. Discuss the content of the literature.

MSX-LA LIFESTYLE ADAPTATIONS

OUTCOME: 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

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.

4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

MSX-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of metabolic syndrome.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

MSX-N NUTRITION

OUTCOME: The patient/family will understand the importance of nutritional management in the improvement of metabolic syndrome.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, making healthy food choices, appropriate serving sizes and food preparation. Refer to registered dietician for MNT as appropriate.
2. Discuss the role of nutrition and weight control in managing or controlling this syndrome. Maintain weight to lessen abdominal obesity in particular.
3. Explain that reducing consumption of alcohol in conjunction to diet modifications can reduce triglycerides. Encourage exercise to aid in correcting abnormal lipids.
4. 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.
    a. 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 healthcare provider.

MSX-SM STRESS MANAGEMENT

OUTCOME: 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 healthy diet

g. Exercising regularly

h. Taking vacations

i. Practicing meditation, self-hypnosis, and positive imagery

j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation

k. Participating in spiritual or cultural activities

6. Provide referrals as appropriate.

MSX-TE TESTS

OUTCOME: 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 and collection method, e.g., FBS, A1C, Lipids.
2. Explain any necessary preparation and instructions prior to the test(s) and how the specimen(s) will be collected.
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 follow-up in the treatment of near drowning.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

NDR-L LITERATURE

OUTCOME: The patient/family will receive literature about near drowning.

STANDARDS:

1. Provide the patient/family with literature on near drowning.
2. Discuss the content of the literature.

NDR-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.

4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

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. Emphasize that children must be supervised when near water even if not swimming.
3. Instruct patients/family 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 (e.g., 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 and collection method.
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. 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 patient/family will understand the importance of follow-up in the treatment of neonatal fever.

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 LITERATURE

OUTCOME: The patient/family will receive literature about neonatal fever.

STANDARDS:

1. Provide patient/family with literature on neonatal fever.
2. Discuss the content of the literature.

NF-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.

2. 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 a incompletely developed immune system) from the potentially devastating consequences of bacterial infection.
3. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
4. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
5. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

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, e.g., 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. Bonding process delays
   e. Breastfeeding complications

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 that 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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in the medical plan.
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 healthcare 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. Emphasize that patients with neurological disorders should not use a sweat lodge alone due to risk of falling or other injury. 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. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Discuss obstacles to a personal exercise plan and solutions to those obstacles. Assist the patient in developing a personal exercise plan.
4. Encourage the patient to increase the intensity and duration of the activity as the patient becomes more fit.
5. Refer to community resources as appropriate.

ND-FU FOLLOW-UP

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

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.
3. Explain that most patients with neurological disorders will need help with medical decision making and encourage them to sign authorizations to share medical

information with family members and/or caregivers. **Refer to "AF-CON Confidentiality" on page 33.**

ND-L LITERATURE

OUTCOME: The patient/family will receive literature about neurological disease.

STANDARDS:

1. Provide the patient/family with literature on neurological disease.
2. Discuss the content of the literature.

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/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements.

Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation

ND-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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.
   c. Refer to a registered dietitian as appropriate.
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 the pain scale and how it is used to assess the degree of pain individuals are experiencing. Discuss it's use in developing a plan to manage pain.
2. Explain that neuropathic pain may be significant and needs to be discussed with the medical provider.
3. 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.
4. 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, e.g., 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 and collection method.
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 and instructions for the test.
5. Explain the meaning of the test results, as appropriate.

ND-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options that may be used to treat the neurological disorder.

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 adaptation, pharmacologic, surgical, and psychosocial aspects of the treatment plan.
3. Discuss the importance of fully participating in the treatment plan, including scheduled follow-up.

O

OBS - Obesity

OBS-C COMPLICATIONS

OUTCOME: The patient will be able to name at least two 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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in the medical plan.
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 healthcare 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 that 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. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Discuss obstacles to a personal exercise plan and solutions to those obstacles. Assist the patient in developing a personal exercise plan.
4. Encourage the patient to increase the intensity and duration of the activity as the patient becomes more fit.
5. Refer to community resources as appropriate.

OBS-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment 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-IR INFORMATION AND REFERRAL

OUTCOME: The patient/family will receive information and referral for alternative or additional services as needed or desired.

STANDARDS:

1. Provide the patient/family with alternative or additional sources for care and services.
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

OBS-L LITERATURE

OUTCOME: The patient/family will receive literature about obesity.

STANDARDS:

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

OBS-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

1. Review dietary modifications and restrictions. Refer to the standards for **"OBS-N Nutrition" on page 624**
2. Emphasize the benefits of regular exercise. **Refer to "HPDP-EX Exercise" on page 480.**
3. Discuss the importance of good hygiene since additional body fat increases perspiration.
4. Discuss the pros and cons of alternate weight loss options, e.g., fad diets, surgery, medications.

OBS-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.

3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

OBS-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for the treatment or management of obesity.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

OBS-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition and obesity.

STANDARDS:

1. Explain the importance of regular meals, especially breakfast for a healthy weight. Discuss the benefits of eating a variety of foods fruits, vegetables, whole grains, lean meats and low fat dairy products.
2. Discuss the benefits of adequate water intake. Reduce the use of sugar beverages, coffee, and alcohol. Avoid between meal snacking as appropriate.
3. Discuss the risks or benefits of popular diets, and refer to a registered dietitian for MNT. Refer to a community weight management program as available.

4. Discuss that overeating may be influenced by psychological or social stressors, depression, or other emotional problems.
5. Explain how reading food labels including how to identify various ingredients on the labels may be helpful in monitoring caloric intake.

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 "HPDP-EX Exercise" on page 480.**
3. **Refer to "HPDP-N Nutrition" on page 483 and "OBS-C Complications" on page 621.**
4. Identify cultural, familial, and personal perceptions of body image and their relationship to obesity and health.

OBS-SCR SCREENING

OUTCOME: The patient/family will understand the importance of screening, follow-up, and the meaning of the results.

STANDARDS:

1. Explain the screening device which will be used.
2. Explain why the screening is being performed.
3. Discuss the meaning of the results of the screening and how the information will be used.
4. Emphasize the importance of follow-up care.
5. Refer to dietitian or other professional(s) as appropriate.

OBS-SM STRESS MANAGEMENT

OUTCOME: 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 healthy diet
    g. Exercising regularly
    h. Taking vacations
    i. Practicing meditation, self-hypnosis, and positive imagery
    j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    k. Participating in 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, preparation for the test, and how the specimen will be collected, as applicable.
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 the meaning of the test results, as appropriate. Explain the BMI, waist circumference, and other screening tests.

ODM - Ocular Diabetes Mellitus

ODM-C COMPLICATIONS

OUTCOME: The patient will understand the ocular complications of diabetes.

STANDARDS:

1. Explain the long-term ocular effects of the condition. Emphasize that the outcome depends upon the patient's control of diabetes.
2. Discuss the symptoms indicative of progression of ocular diabetes.

ODM-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the affect of diabetes on the patient's eyes and vision.

STANDARDS:

1. Review the current information regarding ocular diabetes. Explain that diabetic retinopathy is a result of retinal ischemia and edema which can result in visual loss or total blindness.
2. Explain that the ocular complications of DM result from high blood glucose and that good control of blood glucose helps prevent loss of vision.
3. Explain that high blood glucose levels can cause swelling of the lens of the eye which can result in blurred vision which may resolve when the blood glucose is under good control.
4. Help the patient develop a plan to achieve diabetes control and do not order new glasses until blood glucose is medically lower. Refer to other departments or agencies as appropriate.

ODM-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the status of the ocular condition and the potential to maintain, lose, or regain visual capabilities.
2. Discuss available interventions to help the patient maintain visual capability as much as possible.

3. Discuss the importance of annual dilated eye exams in detecting diabetic retinopathy at an early stage where treatment is most likely to be effective.

ODM-L LITERATURE

OUTCOME: The patient/family will receive literature about ocular diabetes.

STANDARDS:

1. Provide the patient/family with literature on ocular diabetes.
2. Discuss the content of the literature.

ODM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the relationship between elevated blood glucose and loss of vision and will develop a plan to achieve and maintain good blood glucose control.

STANDARDS:

1. Emphasize the importance of diet and weight-control guidelines as they relate to blood sugar control and ocular health. **Refer to "DM-LA Lifestyle Adaptations" on page 323.**
2. Explain that use of tobacco products can exacerbate the disease process and lead to increased loss of vision.
3. Help the patient develop a plan to control blood sugar. Refer to local resources as appropriate.

ODM-LT LASER THERAPY

OUTCOME: The patient will understand the procedure, benefits, and common risks of laser therapy.

STANDARDS:

1. Explain the proposed procedure and indications for the procedure as it relates to the patient's condition.
2. Discuss the common and/or important risks and the potential benefits of the proposed procedure. Explain that the therapy prevents worsening of the condition but probably will not restore any lost vision.
3. Explain the preparation for the procedure.

ODM-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

ODM-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand that pain relief may be available.

STANDARDS:

1. Explain the pain scale and how it is used to assess the degree of pain individuals are experiencing. Discuss it's use in developing a plan to manage pain.
2. Discuss the pain management options which are available.
3. Help the patient develop a plan to monitor and manage pain.
4. Discuss symptoms which should prompt an evaluation such as increasing pain unresponsive to the usual measures.

ODM-TE TESTS

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

STANDARDS:

1. Explain the specific test ordered and collection method.
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 and instructions for the test ordered.

4. Explain the meaning of the test results, as appropriate.

ODM-TX TREATMENT

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

STANDARDS:

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

ORTH - Orthopedics

ORTH-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

ORTH-C COMPLICATIONS

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

STANDARDS:

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

ORTH-DP DISEASE PROCESS

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

STANDARDS:

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

ORTH-EQ EQUIPMENT

OUTCOME: The patient/family/caregiver will understand and demonstrate (when appropriate) the proper use and care of assisted medical devices/equipment for orthopedics.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss the types and the features of the assisted medical devices/equipment as appropriate.
3. Discuss and/or demonstrate the proper use, care, and cleaning of assisted medical devices/equipment.
4. Explain that the patient/family/caregiver will demonstrate the proper use of the assisted medical devices/equipment.
5. Discuss the signs of assisted medical devices/equipment malfunction and the proper action in case of malfunction as appropriate.

ORTH-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

ORTH-L LITERATURE

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

STANDARDS:

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

ORTH-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

ORTH-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.

5. Refer to other providers or community resources as needed.

ORTH-N NUTRITION

OUTCOME: The patient/family will understand the role that nutrition plays in treating orthopedic conditions or injuries.

STANDARDS:

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

ORTH-P PREVENTION

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

STANDARDS:

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

ORTH-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain the pain scale and how it is used to assess the degree of pain individuals are experiencing. Discuss it's use in developing a plan to manage pain.
2. Discuss with the patient/family the risks and benefits of noninvasive and alternative pain relief measures, e.g., medications, TENS units, heat, cold, massage, meditation, imagery, acupuncture, healing touch, traditional healer, hypnosis.

3. Discuss with the patient/family the possible appropriate procedural or operative pain management techniques, e.g., nerve block, intrathecal narcotics, local anesthesia.

ORTH-PRO PROCEDURES

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

STANDARDS:

1. Explain the specific procedure(s) to be performed, including the risks and benefits of performing the procedure and the adverse events that might result from refusal of the procedure.
2. Explain that before the procedure begins, the patient may be asked to participate in marking the location of the procedure.
3. Discuss alternatives to the proposed procedure(s), including expectant management, as appropriate.
4. Discuss the expected involvement in the rehabilitative/recuperative care following the procedure(s).

ORTH-PT PHYSICAL THERAPY

OUTCOME: The patient/family will understand the importance of fully participating in a physical therapy plan.

STANDARDS:

1. Assist the patient/family with a physical therapy plan indicated for this condition/ injury. Explain that this may include visits with the physical therapist as well as home exercises. **Refer to "PT - Physical Therapy" on page 687.**
2. Explain the benefits, risks, and alternatives to the physical therapy plan.
3. Emphasize that it is the responsibility of the patient to follow the plan.

ORTH-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

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

ORTH-TE TESTS

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

STANDARDS:

1. Explain the specific test ordered and collection method.
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 and instructions for the test ordered.
4. Explain the meaning of the test results, as appropriate.

ORTH-TX TREATMENT

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

STANDARDS:

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

ORTH-WC WOUND CARE

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

STANDARDS:

1. Explain the risks and benefits of appropriate wound care and how it relates to the specific condition.
2. Explain how wound care is to be performed; demonstrate as appropriate. Discuss the importance of aseptic technique, appropriate wound care, and proper disposal of soiled wound care items to prevent infection. **Refer to "SWI - Skin and Wound Infections" on page 796.**

OS - Osteoporosis

OS-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of untreated or advanced osteoporosis.

STANDARDS:

1. Explain that the most common complication of untreated or advanced osteoporosis is fracture.
    a. Explain that spinal compression fractures are common and result in back pain and the typical "buffalo hump" often seen in elderly patients.
    b. Explain that fractures of the long bones including fractures of the hip are common and may be debilitating.
2. Explain that pain (especially early morning low back pain) may be a symptom of osteoporosis even in the absence of demonstrable fractures. This can be mistaken for arthritis.
3. Explain that osteoporosis may cause tooth loss secondary to gingival bone loss. Stress the importance of good oral hygiene.

OS-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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in the medical plan.
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 healthcare 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, will require extra caution; for example, patients with osteoporosis should not use the sweat lodge unaccompanied. 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.

OS-DP DISEASE PROCESS

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

STANDARDS:

1. Explain that humans reach their peak bone mass at about 30. After age 30 progressive bone loss typically occurs.
2. Explain that bone loss may be slowed by consistent daily exercise and appropriate calcium intake. **Refer to "OS-N Nutrition" on page 643.**
3. State that progressive bone loss may result in fractures and/or pain. **Refer to "OS-C Complications" on page 639.**
4. Discuss risk factors for earlier onset or more severe osteoporosis, such as petite frame, sedentary lifestyle, smoking, inadequate calcium intake, caffeine intake.
5. Discuss the current state of understanding about the role of estrogen and other hormones as they relate to osteoporosis.

OS-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss the types and the features of the assisted medical devices/equipment as appropriate.
3. Discuss and/or demonstrate the proper use, care, and cleaning of assisted medical devices/equipment.
4. Explain that the patient/family/caregiver will demonstrate the proper use of the assisted medical devices/equipment.
5. Discuss the signs of assisted medical devices/equipment malfunction and the proper action in case of malfunction as appropriate.

OS-EX EXERCISE

OUTCOME: The patient/family/caregiver 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. Discuss medical clearance issues for physical activity.
2. Discuss obstacles to a personal exercise plan and solutions to those obstacles, and assist the patient in developing a personal exercise plan. **Refer to "HPDP-EX Exercise" on page 480.**
3. Explain that exercise should be consistent and of sufficient duration and intensity to obtain the desired outcome. Explain that exercise decreases bone loss by repetitive use of muscle groups. This repetitive use of muscles causes stress on the bones resulting in build-up of bone mass.
4. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image. Explain that exercises involving weight bearing and many muscle groups are more beneficial. Some examples of weight bearing exercises are walking, dancing, bowling, tennis, basketball, volleyball, soccer, and for elderly patients using hand-held weights.
5. Refer to community resources as appropriate.

OS-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

OS-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management plan needed to maintain function and optimal health.

STANDARDS:

1. Review the lifestyle areas that may require adaptation, e.g., diet, exercise.
2. Stress the importance of a calcium rich diet, regular weight-bearing exercise, decreased stress, not smoking, reduced alcohol intake, and estrogen replacement therapy as appropriate.

3. Explain to the patient/family members the importance of proper body mechanics and lifting techniques to avoid injury.
4. Assist family/patient to identify ways to adapt the home to improve safety and prevent injury, e.g., remove throw rugs, install bars in tubs and showers, secure electrical cords.

OS-L LITERATURE

OUTCOME: The patient/family will receive literature about osteoporosis.

STANDARDS:

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

OS-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the current knowledge about the correct amount of calcium intake for a patient of this age. Discuss ways of obtaining calcium, e.g., supplements, dietary intake, calcium based antacids.
    a. As of May 2000 the following are believed to be the correct calcium needs for various age groups as shown in the following table.

Years Old	Dosage
7-9	700 mg
10-12	1000-1400 mg
13-16	1200-1400 mg
19-49	1000 mg
50+	1000-1500 mg

    b. Explain that Vitamin D improves calcium absorption. Discuss ways to get vitamin D, e.g., supplementation, sunlight exposure.
3. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
    a. Discuss medications which may increase the risk for osteoporosis, e.g., thiazide diuretics, magnesium, steroid medications.

4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

OS-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of osteoporosis.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

OS-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition and osteoporosis.

STANDARDS:

1. Discuss that intake of calcium such as dairy products, some greens like turnip greens, kale, broccoli, collard greens and mustard greens, fish with bones like sardines and salmon, and calcium fortified foods, and soy will reduce the risk of developing osteoporosis.
2. Explain that carbonated beverages, very high protein diets, or caffeine the may result in an overall loss of calcium from the body.
3. Explain that adequate intake of Vitamin D is needed to absorb calcium in the diet.
4. Refer to a registered dietitian for MNT as appropriate.

OS-P PREVENTION

OUTCOME: The patient/family will be aware of the methods for reducing the development of osteoporosis.

STANDARDS:

1. Explain how regular exercise increases bone mass thereby reducing the risk of osteoporosis. Regular exercise after age 30 will decrease the rate of bone loss and in some cases may reverse bone loss.
2. Explain that daily intake of calcium will help prevent bone loss and if adequate calcium intake is accomplished in childhood and adolescence there will be a larger peak bone mass.
3. Explain the current knowledge about appropriate intake of calcium for various age levels. **Refer to "OS-M Medications" on page 642.**
4. Explain that certain illnesses, medications, and other factors can increase the risk of developing osteoporosis.

OS-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain the pain scale and how it is used to assess the degree of pain individuals are experiencing. Discuss it's use in developing a plan to manage pain.
2. Explain that pain management is specific to the disease process of this particular diagnosis and may be multifaceted. **Refer to "PM - Pain Management" on page 657.**
3. Explain that there are pharmacological and non-pharmacological that may be helpful in pain management.

OS-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 collection method.
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 and instructions for the test.
5. Explain the meaning of the test results, as appropriate.

OS-TX TREATMENT

OUTCOME: The patient will understand the treatment plan.

STANDARDS:

1. Discuss the importance of fully participating in the treatment plan, including scheduled follow-up.
2. Explain that the major treatment for osteoporosis is physical activity and appropriate intake of calcium and Vitamin D.
3. Explain that some patients will require other medications in addition to the above mentioned treatment. **Refer to "OS-M Medications" on page 642.**

OM - Otitis Media

OM-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of otitis media (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, e.g., 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 otitis media.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

OM-L LITERATURE

OUTCOME: The patient/family will receive literature about otitis media.

STANDARDS:

1. Provide the patient/family with literature on otitis media.
2. Discuss the content of the literature.

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 Weaning" on page 206.**

OM-M MEDICATIONS

OUTCOME: The patient/ family will understand the use of medications in OM.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
   a. Discuss the importance of completing the course of antibiotics (to eradicate the infection and reduce the likelihood of emergence of resistant organisms) as appropriate.
   b. Discuss the indications for and use of chronic suppressive antibiotics as appropriate.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements.

Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

5. Discuss the use of analgesia in pain control. **Refer to "OM-PM Pain Management" on page 648.**

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 Weaning" on page 206.**

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 - Anesthesia" on page 66** and **"SPE - Surgical Procedures and Endoscopy" on page 822.**
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 - Pain Management" on page 657.**
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, e.g., 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 and collection method.
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 and instructions for the test.

OST - Ostomy

OST-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the anatomy and physiology of the function of the affected organ.

STANDARDS:

1. Discuss the anticipated duration of the ostomy (temporary or permanent).
2. Explain the anatomy and functions of the affected organ. Identify and explain the patient's ostomy type.
3. Explain the normal characteristics, function, and classification of the stoma. Explain the color, consistency, amount and frequency of output expected from the ostomy.

OST-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and important complications from the ostomy.

STANDARDS:

1. Explain that complications may be delayed, minimized, or prevented with prompt treatment.
2. Review with the patient/family the signs and symptoms of the common and important complications of the ostomy, e.g., wound infections, peristomal skin breakdown, intestinal obstruction, hemorrhage, peristomal hernia, stoma prolapse, stoma structure, stoma retraction, and stoma necrosis.
3. Discuss symptoms that would require the patient to seek medical attention, such as abnormal abdominal distention; vomiting; blood from the stoma; dusky, dark red, purplish, brown or black stoma; separation between skin and stoma; non-healing peristomal skin irritation or breakdown; lack of output beyond the expected time interval; abdominal pain, protrusion of viscera from stoma, or unusual bulging around the stoma.
4. Discuss the importance of following the prescribed treatment plan, including diet, exercise, medications, hygiene and stress management to help prevent complications.

OST-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology, symptoms, and prognosis of the disease or condition related to the patient's colostomy.

STANDARDS:

1. State the definition of the specific disease or condition related to the colostomy and its effects on the body (**Refer to "CA - Cancer" on page 151**, **"CRN - Crohn's Disease" on page 278**, **"DIV - Diverticulitis / Diverticulosis" on page 341**, and **"UC - Ulcerative Colitis" on page 840**).
2. Review the causative factors of the disease or condition as they relate to the patient.
3. Discuss signs and symptoms and usual progression of the disease or condition.

OST-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate the proper use and care of the ostomy system.

STANDARDS:

1. Refer to ostomy specialty nurse, if available, for selection and fitting of colostomy pouching system.
2. Discuss the types and features of ostomy appliance systems. Discuss the indications for and benefits of the prescribed ostomy appliance system.
3. Discuss and demonstrate proper use, care, storage, and disposal of ostomy system. Participate in return demonstration.
4. Discuss the frequency of evaluation of the ostomy system.
5. Emphasize safe use of the ostomy system e.g., avoid using sharps around pouch, avoid using pin holes in pouch.
6. Inform patient of local ostomy product suppliers and costs, as appropriate. Refer to resources for assistance with ostomy supplies, as appropriate.

OST-EX EXERCISE

OUTCOME: The patient/family will understand the relationship of physical activity to the disease state or condition and to the feelings of well being and will develop a plan to achieve an appropriate activity level.

STANDARDS:

1. Advise the patient to consult with a healthcare provider before starting any exercise program.
2. Explain the benefits of a regular exercise program to health and well being including reduced stress, better sleep, bowel regulation, improved self image, and a sense of well being. **Refer to "HPDP-EX Exercise" on page 480.**

3. Review the basic exercise or activity recommendations of the treatment plan including activity or exercise restrictions.
4. Refer, as appropriate, to community resources or Physical Therapy.

OST-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care. Write down questions that can be discussed at the follow-up visit. Discuss the individual's responsibility in the management of the patient's colostomy.
2. Review the treatment plan with the patient emphasizing the need for making and keeping appointments in order to prevent complications and to make necessary adjustments in medications or treatment.
3. Discuss the signs and symptoms of exacerbation or worsening of the disease that should prompt immediate follow-up.
4. Discuss the availability of community resources, including transportation, and support services and refer as appropriate.

OST-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand, develop, and implement a plan for home management of ostomy.

STANDARDS:

1. Demonstrate and receive return demonstration of ostomy care, as appropriate, including the following:
   a. Cleansing of stoma, peristomal skin care.
   b. Emptying and cleansing of pouch.
   c. Measuring stoma for correct pouch size and application of ostomy pouch.
   d. Irrigating the colostromy.
   e. Burping the colostomy pouch.
   f. Avoiding pinholes in the pouch.
   g. Storing and disposing of ostomy supplies.

2. Emphasize the importance of good personal hygiene. Refer to **"HPDP-HY Hygiene" on page 481****.** Discuss methods of controlling odor with deodorant drops, bismuth/chlorophyll preparations or parsley.
3. Refer, as indicated, to an enterostomal therapist, the United Ostomy Association (800-826-0826) or other local support group for ostomates and other interested persons. Refer to home health, as needed.

OST-L LITERATURE

OUTCOME: The patient/family will receive literature about ostomy.

STANDARDS:

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

OST-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

1. Encourage resumption of activities of daily living. Discuss, as appropriate, adaptations that might be necessary to participate in sports, e.g. caution when participating in contact sports, use of belt or abdominal binder for extra security, framing edges of pouch with waterproof tape for swimming.
2. Explain that modification of clothing is usually not necessary. Discuss any clothing issues that apply or are of concern to the patient/family. Discuss having an ostomy supply kit available to deal with unplanned excrement during work or travel.
3. Encourage verbalization of feelings about the ostomy, body image changes and sexual issues and acknowledge that negative feelings toward the ostomy are normal. Explain, when appropriate, that an ostomy does not preclude a successful pregnancy.
4. Discuss methods of concealing the pouch during intimacy, such as pouch covers, caps, or mini pouches. As indicated, recommend different positions and techniques for sexual activity to decrease stoma friction and skin irritation.
5. Encourage the patient/family to utilize the usual support systems, such as family, church, traditional healers and community groups. Refer to Behavioral Health and other community resources as necessary.

OST-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

OST-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for treatment or management of the ostomy.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

OST-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition and to assist in the control of the ostomy function.

STANDARDS:

1. Assess current dietary habits to determine patterns and preferences. Identify any bowel irritants.
2. Recommend consistency and moderation in dietary habits.
3. Discuss gas-forming and odor-producing foods, such as beans, cabbage, broccoli, Brussels sprouts and cauliflower. Stress the trial-and-error method to establish which foods can be tolerated. Discuss introducing new foods one at a time.
4. Discuss eating slowly, no excessive talking, chewing food well, and eating regular meals. Stress avoiding carbonated beverages, drinking with a straw, and temperature extremes of foods.
5. Recommend that the patient should avoid foods that contribute to diarrhea, such as prunes, coffee, fruit juices, alcohol, and certain fruits and vegetables. Discuss foods that provide bulk, such as applesauce, bananas, smooth peanut butter, cheese, boiled rice, and yogurt. Refer to a registered dietitian for MNT.

OST-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management as it relates to bowel function.

STANDARDS:

1. Explain that uncontrolled stress can increase constipation or diarrhea, abdominal pain, and fatigue.
2. Explain that effective stress management may help reduce the severity of constipation or diarrhea, abdominal pain, and fatigue, as well as, helping to improve health and a sense of well-being.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol, or other substance use as well as inappropriate eating, all of which can increase the risk of morbidity. **Refer to "OST-N Nutrition" on page 654.**
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 healthy diet
g. Exercising regularly
h. Taking vacations
i. Practicing meditation, self-hypnosis, and positive imagery
j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
k. Participating in spiritual or cultural activities

5. Provide referrals as appropriate.

OST-WC WOUND CARE

OUTCOME: The patient/family will understand and demonstrate the procedure for ostomy related wound care.

STANDARDS:

1. Explain the reasons for appropriate stoma care, e.g. decreased infection rate, decreased odor, decreased peristomal skin breakdown.
2. Discuss signs and symptoms that should prompt immediate follow-up, e.g. peristomal skin redness, breakdown or discharge, change in stoma color, decreased drainage, diarrhea, abdominal distention with cramping pain, nausea, vomiting, enlargement of stoma, unattainable pouch seal, or moderate bright red stomal drainage. **Refer to "OST-HM Home Management" on page 652.**

P

PM - Pain Management

PM-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain that pain normally acts as the body's warning signal of tissue injury. This warning signal notifies the body to withdraw from the stimulus.
2. Discuss the difference between the body's physiological response to pain and the person's perception of the event.
3. Explain that tissue damage causes the release of chemicals which result in the sensation of pain. Most pain medications work by blocking these chemicals.

PM-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

PM-DP DISEASE PROCESS

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

STANDARDS:

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

PM-EQ EQUIPMENT

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

STANDARDS:

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

PM-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Discuss obstacles to a personal exercise plan and solutions to those obstacles. Assist the patient in developing a personal exercise plan.
4. Encourage the patient to increase the intensity and duration of the activity as the patient becomes more fit.
5. Refer to community resources as appropriate.

PM-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

PM-L LITERATURE

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

STANDARDS:

1. Provide patient/family with literature on pain management.
2. Discuss the content of the literature.

PM-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

1. Explain that treatment of pain is very individualized, e.g., medication, rest, exercise, and disease-specific treatment modalities.
2. Explain that exercise and social involvement (e.g., familial, traditional, cultural) may decrease the subjective sense of pain and the depression and anger often associated with pain.
3. Review lifestyle areas that may require adaptations (e.g., diet, physical activity, sexual activity, bladder/bowel habits, role changes, communication skills, and interpersonal relationships). Discuss lifestyle changes in relation to disease progression. Review activity limitation as appropriate.
4. Discuss techniques that may reduce stress and depression such as meditation and biofeedback as appropriate. **Refer to "CPM-SM Stress Management" on page 253.**
5. Refer to community resources as appropriate**.** **Refer to "HPDP - Health Promotion Disease Prevention" on page 479**.

PM-M MEDICATIONS

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

STANDARDS:

1. Explain that chronic pain is usually irreversible and progressive, often requiring medication therapy.
2. Describe the name, strength, purpose, dosing directions, and storage of the medication.
3. Discuss the risks, benefits and common or important side effects of the medication and follow up as appropriate.
    a. Discuss the use of adjunctive medication, if indicated, to control analgesic side effects, e.g., anti-emetics, laxatives, antacids. Emphasize the importance of developing a plan with the provider to address these issues as appropriate.
    b. Emphasize that excess sedation and euphoria are not goals of palliative pharmacologic therapy.
4. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.

5. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.
6. Discuss patient/family concerns about addiction. Explain the difference between psychological addiction and physical dependence upon prescribed pain medications. Reinforce that addiction is psychological dependence on a drug; and is not equivalent to tolerance or physical dependence.

PM-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of pain management.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PM-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition and pain management.

STANDARDS:

1. Explain that constipation is a common side-effect of opiates. Dietary measures such as increased water, increased fiber, increased fruit juices and decreased intake of milk products may be helpful.
2. Review the patient's prescribed diet, if applicable. Refer to a registered dietitian for MNT.

PM-P PREVENTION

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

STANDARDS:

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

PM-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the treatment options available for psychotherapy as related to pain management.

STANDARDS:

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

PM-TE TESTS

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

STANDARDS:

1. Explain the specific test ordered and collection method.
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 and instructions for the test ordered.
4. Explain the meaning of the test results, as appropriate.

PM-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options and will participate in the design of the treatment plan, goals, and expected results.

STANDARDS:

1. Discuss with the patient/family the risks and benefits of noninvasive and alternative pain relief measures, e.g., medications, TENS units, heat, cold, massage, meditation, imagery, acupuncture, healing touch, traditional healer, hypnosis.
2. Discuss with the patient/family the possible appropriate procedural or operative pain management techniques, e.g., nerve block, intrathecal narcotics, local anesthesia.

PC - Pancreatitis

PC-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

PC-DP DISEASE PROCESS

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

STANDARDS:

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

PC-FU FOLLOW-UP

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

STANDARDS:

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

PC-L LITERATURE

OUTCOME: The patient/family will receive literature about pancreatitis.

STANDARDS:

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

PC-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

PC-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:

a. Assessment of the nutrition related condition.
b. Identification of the patient's nutritional problem.
c. Identification of a specific nutrition intervention therapy plan.
d. Evaluation of the patient's nutritional care outcomes.

2. Reassessment as needed.
3. Review the basic nutrition recommendations for the treatment plan.
4. Discuss the benefits of nutrition and exercise to health and well-being.
5. Assist the patient/family in developing an appropriate nutrition care plan.
6. Refer to other providers or community resources as needed.

PC-N NUTRITION

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

STANDARDS:

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

PC-P PREVENTION

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

STANDARDS:

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

PC-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that pain management in pancreatitis is specific to the disease process of this particular patient and may be multifaceted.
2. Explain that often antispasmodics may be helpful.
3. Explain that short term use of narcotics may be helpful in pain management.
4. Explain that other medications may be helpful to control the symptoms of nausea and vomiting.
5. Explain that administration of fluids may help with pain relief and resolution of symptoms.
6. **Refer to "PM - Pain Management" on page 657.**

PC-TE TESTS

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

STANDARDS:

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

PC-TX TREATMENT

OUTCOME: The patient will understand the treatment plan.

STANDARDS:

1. Explain that pancreatic secretions can be minimized by eliminating oral ingestion of food and fluid. This must be done to "rest" the pancreas.
2. Explain the proper use of pain medications. **Refer to "PM - Pain Management" on page 657.**
3. Explain that, if the pancreatitis episode is prolonged, total parenteral nutrition may be required to maintain nutrition and promote healing.

4. Refer to community resources as appropriate.

PNL - Perinatal Loss

PNL-C COMPLICATIONS

OUTCOME: Patients will know that the most serious complications of perinatal loss are infection, hemorrhage, and possible decrease in fertility.

STANDARDS:

1. Instruct patient on the signs and symptoms of postpartum complications, e.g., hemorrhage, infections, and the possibility of decreased fertility.
2. Explain that a common complication of perinatal loss is depression and that this is usually treatable.
3. Explain that marital difficulties are common after perinatal loss. Encourage open discussion and family counseling or support groups as appropriate.

PNL-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

PNL-DP DISEASE PROCESS

OUTCOME: The patient and significant others(s) will understand the type of perinatal loss they had, e.g., miscarriage, ectopic pregnancy, intrauterine death, or stillbirth.

STANDARDS:

1. Explain that perinatal loss is common and is most often not a result of actions or lack of actions of the mother.
2. Explain to the patient and significant others what type of perinatal loss the patient had, e.g., miscarriage, stillbirth.
3. Explain to the patient and significant others what the course of the medical treatment will be, e.g., incomplete miscarriage, dilation and curettage, stillbirth, induction of labor, and vaginal delivery.
4. If appropriate, explain the cause for perinatal loss if one can be identified.
5. If possible explain the implications of this loss on future pregnancies.

PNL-FU FOLLOW UP

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

STANDARDS:

1. Instruct patient/family when to return for follow up visits.
2. Instruct patient/family to call or return immediately to the hospital or clinic for any signs of complication.
3. Refer for family planning as appropriate.

PNL-GP GRIEVING PROCESS

OUTCOME: The patient and significant other(s) will understand the grieving process, signs, and symptoms as it pertains to miscarriage, ectopic pregnancy, stillbirth, or neonatal death.

STANDARDS:

1. Discuss that culture plays an important role in the grieving process. (Before any teaching/counseling is initiated a discussion with the patient and significant other(s) will be done to ascertain any cultural beliefs and or taboos associated with death and the grieving process. Cultural preferences should be honored.)

2. Explain that grief is a personal process and patients and significant others(s) may have different reactions to the loss. Offer grief information and different options to assist their grieving process.
3. Discuss the grieving process as it relates to perinatal loss.
4. Explain that it is normal to grieve over the loss of the baby, and that everyone may grieve differently, and that different reactions are normal.
5. Explain that anniversary reactions, increased grief during trigger events (e.g., pregnancy of a friend or family member, holidays) are normal.
6. Discuss the various options available to help with the grieving process.
7. As appropriate, encourage viewing of the infant/fetus, picture taking, and naming of the infant/fetus.

PNL-L LITERATURE

OUTCOME: The patient/family will receive literature about perinatal loss and/or related issues.

STANDARDS:

1. Provide the patient/family with literature on perinatal loss and/or related issues.
2. Discuss the content of the literature.

PNL-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.
5. Encourage continued use of prenatal vitamins as appropriate.

PNL-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PNL-N NUTRITION

OUTCOME: The patient will understand the need for a balanced diet or special diet as indicated by her medical condition.

STANDARDS:

1. Instruct patient on diet prior to discharge.
2. Encourage patient to continue taking prenatal vitamins or multi vitamin with folic acid.
3. Refer as appropriate to registered dietician or other resources as available.

PNL-PM PAIN MANAGEMENT

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

STANDARDS:

1. Discuss pain relieving and/or pain management techniques.
2. Patient will be instructed on pain medication available to her and encourage to ask for the medication as needed to relieve her pain.

3. Discuss that pain associated with perinatal loss can be physical, emotional, and spiritual. Different techniques may be required to address each type of pain.
4. Discuss non-pharmacologic, traditional or spiritual techniques to address emotional and spiritual needs.

PNL-SM STRESS MANAGEMENT

OUTCOME: The family member will understand the role of stress management in perinatal loss.

STANDARDS:

1. Explain that perinatal loss may lead to uncontrolled stress, which can contribute to physical illness, emotional distress, and early mortality of the family member.
2. Explain that effective stress management may enable the family member to deal with their loss, as well as, help improve their health and well-being.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol, or other substance use as well as overeating, all which can increase the risk of depression or suicidal behaviors.
4. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. Becoming aware of your own reactions to stress
    b. Recognizing and accepting your limits
    c. Talking with people you trust about your worries or problems
    d. Setting realistic goals
    e. Getting enough sleep
    f. Maintaining a healthy diet
    g. Exercising regularly
    h. Taking vacations, meditation, and self-hypnosis
    i. Using positive imagery
    j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    k. Participating in spiritual or cultural activities
5. Provide referrals as appropriate.

PNL-TX TREATMENT

OUTCOME: The patient/family will understand the treatment necessary as a result of the perinatal loss if any.

STANDARDS:

1. Explain to the patient and significant others the course of the medical treatment, e.g., dilation and curettage, induction of labor and vaginal delivery, laparoscopy or open abdominal surgery.
2. Discuss issues related to sexual activity and family planning, as appropriate.

PD - Periodontal Disease

PD-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the supportive structures of the tooth.

STANDARDS:

1. Discuss the importance of the supportive structures of the tooth which are composed of attached tissue, periodontal ligaments and alveolar bone.

PD-C COMPLICATIONS

OUTCOME: The patient/family will understand some of the complications of periodontal disease.

STANDARDS:

1. Discuss that periodontal disease may cause seeding of the blood with bacteria. Some of the complications of this may be:
   a. Valvular heart disease
   b. Myocardial infarction
   c. Stroke
   d. Low birth-weight infants
   e. Pre-term delivery
2. Discuss that periodontal disease often results in loss of alveolar bone and loosening of teeth. This may eventually result in tooth loss.
3. Discuss that periodontal disease almost always results in bad breath.
4. Discuss that periodontal disease may result in dental caries. **Refer to "DC - Dental Caries" on page 306.**

PD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the periodontal disease process and list some of the causes.

STANDARDS:

1. Explain that bacterial plaque release toxins that irritate and damage the gums. Over time this infectious process may progress to involve the supporting structures of the tooth leading to bone loss and eventual loss of the tooth/teeth.

2. Explain that genetics and lifestyle choices play a role in the development of periodontal disease, e.g., diseases of the immune system, uncontrolled diabetes, and tobacco and/or alcohol use.
3. Explain that early seeding of the mouth with pathologic bacteria may predispose to the development of periodontal disease.

PD-FU FOLLOW-UP

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

STANDARDS:

1. Explain the course of treatment for the current disease process, including the schedule for treatments and follow-up.
2. Emphasize the importance of following the current recommendations for routine dental examination and periodontal maintenance appointments.
3. Emphasize the importance of a dental visit if any problems occur between scheduled dental visits.
4. Assist the patient in making follow-up appointments and refer to outside providers as appropriate.

PD-HY HYGIENE

OUTCOME: The patient/family will recognize good oral hygiene as an aspect of wellness.

STANDARDS:

1. Discuss hygiene as part of a positive self image.
2. Review daily dental hygiene habits.
3. Discuss the importance of daily oral care in preventing cavities and gum disease.

PD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about periodontal disease, its treatment and/or the oral care necessary for prevention/maintenance of disease.

STANDARDS:

1. Provide patient/family with written patient information literature on periodontal disease, treatment and/or the oral care necessary for prevention/maintenance of disease.
2. Discuss the content of the patient information literature with the patient/family.

PD-M MEDICATIONS

OUTCOME: The patient/family will understand the importance of medication in the treatment of the periodontal disease and will 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. Discuss the use of chlorhexidine as appropriate. Discuss the common and important side-effects, common or important drug interactions (e.g., fluoride) and indications for immediate follow-up.
3. Explain the importance of completing the course of therapy and its role in eradicating the infection and/or decreasing the infectiousness of the periodontal disease.
4. Explain, as appropriate, that failure to complete the course of antibiotics may cause the development of resistant organisms.
5. Discuss, as appropriate, the concomitant use of antipyretics or NSAIDS.

PD- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of periodontal disease.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
    a. Assessment of the nutrition related condition.
    b. Identification of the patient's nutritional problem.
    c. Identification of a specific nutrition intervention therapy plan.
    d. Evaluation of the patient's nutritional care outcomes.
    e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PD-N NUTRITION

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

STANDARDS:

1. Discuss the relationship between a diet high in carbohydrates, especially simple sugars, and the development of dental caries. Give examples of foods high in simple sugars, e.g., crackers, potato chips, candy, pre-sweetened cereals.
2. Discuss the importance of calcium and fluoride intake as it relates to tooth development/mineralization.
3. Discuss foods that may be contraindicated secondary to instability of the teeth, e.g., apples, corn on the cob.
4. Refer to a registered dietitian as appropriate.

PD-P PREVENTION

OUTCOME: The patient will be able to identify some ways to help prevent periodontal disease.

STANDARDS:

1. Early entry (prenatal and infancy) into dental care is important in the prevention of periodontal disease.
2. Emphasize the importance of treating all family members with periodontal disease, especially if the family includes children ages 6 months to 8 years.
3. Explain that the best preventive measures are daily plaque removal, primarily by brushing and flossing.
4. Emphasize the importance of regular and timely dental examination and professional cleaning in the prevention of periodontal disease.

PD-PM PAIN MANAGEMENT

OUTCOME: The patient/family will 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 - Pain Management" on page 657**.
2. Explain that short-term use of Tylenol, NSAIDS, and/or narcotics may be helpful in pain management as appropriate.
3. Explain that antibiotics may be helpful in pain relief.

4. Explain non-pharmacologic measures that may be helpful with pain control, e.g., avoid firm foods.
5. Explain that dental anxiety may be controlled or relieved by the use of anxiolytics or antihistamines as appropriate.
6. Explain that local anesthetics and/or nitrous oxide may be used to control pain during dental procedures.

PD-PRO PROCEDURES

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

1. Explain the basic procedure to be used and the indication, common complications and alternatives as well as the risks of non-treatment.
2. Explain that dental anxiety may be controlled or relieved by the use of anxiolytics or antihistamines as appropriate.

PD-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the risk(s)/ benefit(s) of the test(s) and the risk(s) of refusal of the test(s).

STANDARDS:

1. Discuss the test(s) to be performed, e.g., x-ray, bacteriological testing, periodontal probing.
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment. Discuss the risks of non-performance of the testing.

PD-TO TOBACCO

OUTCOME: The patient/family will understand the role of tobacco use in periodontal disease.

STANDARDS:

1. Discuss that tobacco use is a significant risk factor for development of dental disease and tooth loss.
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. **Refer to "TO - Tobacco Use" on page 828.**

PD-TX TREATMENT

OUTCOME: The patient will understand the necessary treatment (e.g., scaling and root planning, chemotherapeutics, surgical treatment) and the proper oral care after treatment.

STANDARDS:

1. Explain the proposed procedure including indications, risks, benefits, alternatives and the consequences of non-treatment.
2. Review the specific elements of periodontal maintenance after treatment, e.g., daily plaque removal, use of oral rinses, and keeping scheduled appointments.

PVD - Peripheral Vascular Disease

PVD-C COMPLICATIONS

OUTCOME: The patient/family will understand how to prevent the complications of PVD.

STANDARDS:

1. Discuss common and important complications of PVD, e.g., injury, infection, amputation.
2. Emphasize early medical intervention for any injury, increased pain, decreased sensation, or signs/symptoms of infection (pain, redness, warmth).

PVD-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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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.

PVD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of PVD.

STANDARDS:

1. Explain that PVD is the result of the buildup of plaque in the interior walls of the vessels supplying the extremities.
2. Explain that PVD is a chronic, progressive, and treatable disease.
3. Review the factors related to the development and progression of PVD (tobacco use, HTN, DM, obesity, and hyperlipidemia). Emphasize that patients with PVD are at greatly increased risk for other vascular diseases (CAD, CVA).
4. Review the symptoms of PVD (pain in extremities during exercise, coolness of hands and/or feet, ulcers of the extremities, skin pallor).

PVD-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of adhering to a treatment regimen, be able to identify appropriate actions to take for symptoms indicating life- or limb-threatening ischemia, and will make a plan to obtain and keep appropriate follow-up appointments.

STANDARDS:

1. Discuss the individual's responsibility in the management of peripheral vascular disease.
2. Review treatment plan with the patient, emphasizing the need for keeping appointments, fully participating with medication therapy, adhering to dietary modifications, and maintaining an appropriate activity/rest balance.
3. Review the symptoms which should be reported and evaluated, e.g., symptoms more frequent or occurring during rest, symptoms lasting longer.

PVD-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the lifestyle adaptations necessary to maintain optimal health.

STANDARDS:

1. Emphasize that the most important component of home management in the prevention and treatment of peripheral vascular disease is the patient's adaptation to a healthier, lower risk lifestyle.
2. Discuss lifestyle adaptations that may reduce further risk of peripheral vascular disease and improve the quality of life (cease use of tobacco products, control hypertension and elevated cholesterol through medications, diet and exercise, lose weight as indicated, control diabetes, and increase activity as prescribed by the physician).

PVD-L LITERATURE

OUTCOME: The patient/family will receive literature about peripheral vascular disease.

STANDARDS:

1. Provide the patient/family with literature on peripheral vascular disease.
2. Discuss the content of the literature.

PVD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adaptations necessary to maintain optimal health.

STANDARDS:

1. Emphasize that the most important component in the prevention and treatment of peripheral vascular disease is the patient's adaptation to a healthier, lower risk lifestyle.
2. Discuss lifestyle adaptations that may reduce further risk of peripheral vascular disease and improve the quality of life (cease use of tobacco products, control hypertension and elevated cholesterol through medications, diet and exercise, lose weight as indicated, control diabetes, and increase activity as prescribed by the physician).

PVD-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

PVD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PVD-N NUTRITION

OUTCOME: The patient/family will understand how to control peripheral vascular disease through weight control and diet modification and will develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess the current nutritional habits.
2. Review the relationship between diet and peripheral vascular disease, hypertension, elevated cholesterol, and obesity.
3. Provide lists of foods that are to be encouraged and avoided. Refer to registered dietician or other local resource as available.
4. Assist in developing an appropriate diet plan to achieve optimal weight and control cholesterol.
5. **Refer to "LIP - Hyperlipidemia/Dyslipidemias" on page 517**.

PVD-P PREVENTION

OUTCOME: The patient/family will understand ways to prevent PVD.

STANDARDS:

1. Discuss that prevention of peripheral vascular disease is far better than controlling the disease after it has developed.
2. Explain that consuming a diet low in fat and controlling weight and blood pressure will help to prevent PVD.
3. Discuss that persons with uncontrolled diabetes and uncontrolled hypertension are more likely to develop PVD. Stress the importance of controlling these disease processes. **Refer to "DM - Diabetes Mellitus" on page 318 and "HTN - Hypertension" on page 524.**

PVD-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 - Pain Management" on page 657.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Discuss non-pharmacologic measures that may be helpful with pain control.

PVD-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Explain the test ordered (Doppler ultrasound, angiography).
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment.

PVD-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be performed based on the test results.

STANDARDS:

1. List the possible procedures that might be utilized to treat the peripheral artery blockage, e.g., angioplasty, arterial bypass.
2. Briefly explain each of the possible treatments.
3. Explain that the treatment decision will be made by the patient and medical team after reviewing the results of the diagnostic tests.

PT - Physical Therapy

PT-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate as appropriate proper use of equipment.

STANDARDS:

1. Discuss indications for and benefits of prescribed equipment.
2. Discuss types and features of medical equipment as appropriate.
3. Discuss and/or demonstrate the proper use and care of medical equipment. Participate in return demonstration by patient/family as appropriate.
4. Discuss signs of equipment malfunction and the proper action to take in case of malfunction.
5. Emphasize safe use of equipment. Discuss proper disposal of any associated medical supplies.

PT-EX EXERCISE

OUTCOME: The patient/family will relate exercise program to optimal health and plan to follow the customized exercise program developed with the Physical Therapist.

STANDARDS:

1. Review the benefits of regular exercise.
2. Discuss the three types of exercise: aerobic, flexibility, and endurance, as appropriate.
3. Review the recommendations of an exercise program:
    a. Start out slowly.
    b. Modification of exercises to accommodate specific health problems.
    c. Exercise according to the specific plan developed for the individual.
4. Discuss the exercise(s) in the customized program.
5. As appropriate, demonstrate and assist in practicing the exercise(s) in the program.
6. Emphasize the importance of following the customized exercise plan developed with the Physical Therapist to achieve optimal benefit.
7. Review the exercise programs available in the community.

PT-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of fully participating with the treatment plan and the process for obtaining follow-up appointments.

STANDARDS:

1. Discuss the patient's responsibility in the management of the condition.
2. Emphasize the importance of making and keeping appropriate follow-up appointments.
3. Discuss the process for obtaining follow-up appointments.

PT-GT GAIT TRAINING

OUTCOME: The patient will understand the importance of improved gait and the plan to practice.

STANDARDS:

1. Discuss the components necessary for optimal gait:
   a. Normal range of motion
   b. Proper cadence or rhythm
   c. Appropriate stride length
   d. Heel-to-toe pattern to step
2. Discuss the importance of normal range of motion as appropriate. Demonstrate and assist in return demonstrations of specific exercises to increase the range of motion of the affected joint(s) or extremity(s).
3. Discuss the value of cadence or rhythm in walking as appropriate. Demonstrate and assist to accomplish an improved cadence.
4. Discuss stride length as appropriate. Demonstrate appropriate stride length and assist in improving stride.
5. Discuss and demonstrate the usual heel-to-toe pattern of a normal step as appropriate. Assist the patient to learn modification techniques.
6. Emphasize the importance of intentionally practicing improved gait.

PT-I INFORMATION

OUTCOME: The patient/family will understand their physical condition as it relates to their disease process and the rehabilitative process.

STANDARDS:

1. Review the current information about the patient's specific diagnosis.

2. Review the effects that this condition has on the patient's physical status. Emphasize the short/long term effects and the degree of control that the patient has over the condition.
3. Discuss the symptoms that may indicate progression of the condition.

PT-L LITERATURE

OUTCOME: The patient/family will receive literature about the physical therapy plan.

STANDARDS:

1. Provide the patient/family with literature on the physical therapy plan.
2. Discuss the content of the literature.

PT-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will have an understanding of the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PT-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 condition.
4. Emphasize the importance of fully participating in the prescribed nutritional plan.

PT-TX TREATMENT

OUTCOME: The patient/family will understand the common and important risks, anticipated benefits and anticipated progress of the patient's rehabilitation process.

STANDARDS:

1. Review the current information regarding the treatment of the condition.
2. Explain the benefits of the proposed treatment.
3. Assist the patient/family in development of a treatment plan which will achieve treatment goals.
4. Refer to other departments or community resources as appropriate.

PT-WC WOUND CARE

OUTCOME: The patient/family will 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, e.g., 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, e.g., 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.

PNM - Pneumonia

PNM-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand and identify the symptoms associated with pneumonia and the appropriate actions to prevent complications.

STANDARDS:

1. Discuss the possible complications, e.g. pleural effusion, pleurisy, lung abcess sustained hypotension and shock, other infections such as bacterium, 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 worsen to contact the patient's physician.
4. Explain the common symptoms such as fever, cough, chest pain, shortness of breath.

PNM-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications associated with pneumonia.

STANDARDS:

1. Discuss the complications, e.g. pleural effusion, pleurisy, lung abcess, sustained hypotension and shock, other infections such as bacterium, 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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in the medical plan. (Stoic Fatalism)

2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are interactions with prescribed treatment.
3. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
4. Discuss that traditions, such as sweat lodges, cultural/traditional smoking, may affect some conditions in detrimental ways. Healing practices or using a traditional healer may have a positive effect on the patient's condition.
5. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PNM-DP DISEASE PROCESS

OUTCOME: The patient/family 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 an infectious agent making it hard for lungs to get oxygen into the blood.
2. Explain that pneumonia may be contracted by aspiration of oropharyngeal contents, by inhalation of respiratory secretions from infected individuals, through the bloodstream, or directly during surgery or trauma.
3. Explain that patients with bacterial pneumonia may have had an underlying disease that impairs the defenses, such as a preceding viral illness.
4. Explain that weakness and fatigue may persist for weeks after the infection. Encourage a gradual return to normal activities.

PNM-EQ EQUIPMENT

OUTCOME: The patient/family will understand 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 the proper use, care, cleaning of medical equipment and proper disposal of associated medical supplies.
4. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
5. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.

6. Emphasize the importance of not tampering with any medical device.

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 in the treatment of pneumonia.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss the signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

PNM-IS INCENTIVE SPIROMETRY

OUTCOME: The patient/family will understand the use of the incentive spirometer.

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 that 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 LITERATURE

OUTCOME: The patient/family will receive literature about pneumonia.

STANDARDS:

1. Provide the patient/family with literature on pneumonia.
2. Discuss the content of the literature.

PNM-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
    a. Explain the importance of completing the full course of antibiotic therapy, as prescribed, to prevent antibiotic resistance and to facilitate complete recovery as appropriate.
2. Discuss the risks, benefits and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discourage the use of cough suppressants for a productive cough.
5. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

PNM-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of pneumonia.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
    a. Assessment of the nutrition related condition.
    b. Identification of the patient's nutritional problem.

c. Identification of a specific nutrition intervention therapy plan.
d. Evaluation of the patient's nutritional care outcomes.
e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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.
2. Discuss that small frequent meals help to meet energy needs especially in acute state.

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 respiratory infections.
2. Discuss the importance of tobacco cessation. **Refer to "TO - Tobacco Use" on page 828**.
3. Explain that balanced nutrition, rest, and exercise are important to optimal health.
4. Encourage patient (particularly if elderly or chronically ill) to obtain immunizations against influenza and pneumococcus. **Refer to "IM - Immunizations" on page 547**.

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-SHS SECOND-HAND SMOKE

OUTCOME: The patient/family will understand the adverse health consequences associated with exposure to second-hand tobacco smoke.

STANDARDS:

1. Define "passive smoking" and ways in which exposure occurs, e.g., smoldering tobacco, exhaled smoke, residue in carpet.
2. Discuss harmful substances in smoke e.g., nicotine, benzene, CO, carcinogens.
3. Explain the increased risk of complications in children and adults when exposed to tobacco smoke.
4. Discuss that having household members smoke outside and removing smoke contaminated clothing may decrease exposure to second hand smoke.
5. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness.
6. Encourage smoking cessation or at least never smoking in the home or car. **Refer to "TO-QT Quit" on page 832.**

PNM-TCB TURN, COUGH, DEEP BREATH

OUTCOME: The patient/family will understand why it is important to turn, cough, and deep breath.

STANDARDS:

1. Explain that it is important to frequently (every 1 to 2 hours) turn, cough, and breathe deeply. Explain that 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). Return demonstration as appropriate.

PNM-TE TESTS

OUTCOME: The patient/family 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 infectious organism and most effective treatment can be identified from a sputum culture and sensitivity.
3. Explain that blood cultures and other tests may assist in diagnosis and treatment.
4. Discuss the risks/benefits of tests ordered and the risk of refusal of testing.

PNM-TO TOBACCO (SMOKING)

OUTCOME: The patient and/or family will understand the dangers of smoking.

STANDARDS:

1. Explain the increased risk of complications and chronic lung disease in the patient with pneumonia 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. **Refer to "TO - Tobacco Use" on page 828**.

PNM-TX TREATMENT

OUTCOME: The patient/family will understand the appropriate treatment for pneumonia.

STANDARDS:

1. Explain that antibiotics are necessary to treat the pneumonia. **Refer to "PNM-M Medications" on page 694.**
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 LITERATURE

OUTCOME: The patient/family will receive literature about poison prevention.

STANDARDS:

1. Provide the patient/family with literature about poison prevention.
2. Discuss the content of the literature.

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, e.g., 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 - Suicidal Behavior" on page 808.**

PP - Postpartum

PP-C COMPLICATIONS

OUTCOME: The patient/family will understand how to identify and prevent complications of the postpartum period.

STANDARDS:

1. Explain the need for immediate medical care for excessive bleeding, abdominal pain, cough or chest pain, fever, leg pain, or feeling of depression.
2. Discuss the etiology of blood clots, bleeding, and infection in the postpartum period. Discuss that some pain and bleeding is normal immediately after delivery. Excessive bleeding (or hemorrhage) occurs most often after long labors, multiple births, or when the uterus has become infected.
3. Explain that sometimes an incision called an episiotomy is made during delivery to keep the vagina from tearing. Explain that sitz baths, cold packs, or warm water applied to the area can help avoid infection, promote healing, and reduce tenderness.
4. Discuss the more common complications of pregnancy and delivery (e.g., stretch marks, hemorrhoids, constipation, urge or stress urinary or fecal incontinence, hair loss, dyspareunia, as appropriate). Advise that fatigue and headaches are common.
5. As appropriate, **refer to "BF - Breastfeeding" on page 135** and/or **refer to "PDEP - Postpartum Depression" on page 707**.

PP-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. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are interactions with prescribed treatment.
3. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
4. 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.

5. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PP-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up for postpartum.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

PP-I INFORMATION

OUTCOME: The patient/family will understand postpartum changes.

STANDARDS:

1. Discuss the physical changes: lochia, after-pains, breast engorgement (breastfeeding or not), weight loss, hair loss, and fatigue.
2. Discuss the common postpartum emotional changes. Encourage the patient to share her feelings with her partner, friend, family, PHN, or behavioral health professional.
3. Discuss the changes in interpersonal relationships and family dynamics. Identify stressors that can occur with a newborn in the household. Encourage the patient to "take time for herself and ask for help."
4. Explain that infant sleep patterns differ from adult sleep patterns. Encourage the mother to sleep when the infant sleeps.
5. Emphasize the importance of parent-child bonding.
6. Discuss the importance of a healthy lifestyle. **Refer to "HPDP - Health Promotion Disease Prevention" on page 479.**
7. Discuss options for contraception. **Refer to "FP - Family Planning" on page 387.**

PP-INF INFANT CARE

OUTCOME: The patient/family will understand the basic principles of infant care.

STANDARDS

1. Explain the supplies necessary for care of an infant.
2. Discuss diapering, bathing, cord care, burping, skin care, and feeding.
3. Explain that not exposing the infant to second hand smoke, and laying the infant on the side or back for sleep reduces the incidence of SIDS. **Refer to "SIDS - Sudden Infant Death Syndrome" on page 804.**
4. Explain the proper use and installation of infant car seats. **Refer to "CHN-CAR Car Seats and Automobile Safety" on page 182**.
5. Discuss circumcision care as applicable.
6. Explain that all infants sneeze. Discuss that nasal secretions are common. Discuss the procedure for using a nasal suction bulb. Discuss other common newborn sounds and behaviors; newborn sigh, startle reflex, twitching during sleep.
7. Explain that infants frequently have rashes that may be normal. Emphasize that it is recommended to check with the healthcare provider.
8. Emphasize that a temperature greater than 100.4°F taken rectally in a newborn (less than 60 days old) should prompt immediate medical attention. This may be a sign of a life threatening condition.

PP KE KEGEL EXERCISES

OUTCOME: The patient/family will understand how to use Kegel exercises to prevent urinary stress incontinence.

STANDARDS:

1. Review the basic pelvic floor anatomy.
2. Define stress incontinence and discuss its causes.
3. Teach Kegel exercises. Encourage frequent practice of Kegel exercises.

PP-L LITERATURE

OUTCOME: The patient/family will receive literature about postpartum issues.

STANDARDS:

1. Provide the patient/family with literature on postpartum issues.
2. Discuss the content of the literature.

PP-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

PP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for postpartum care.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PP-N NUTRITION

OUTCOME: The patient will understand the role of nutrition and postpartum care.

STANDARDS:

1. Explain the meaning of a balanced nutrition for optimal health.
2. Discuss the importance of adequate fluid intake.
3. Refer to a registered dietitian for MNT as appropriate.

PP-NJ NEONATAL JAUNDICE

OBJECTIVE: The parent/family will understand the importance of monitoring for jaundice and the complications of unrecognized jaundice.

STANDARDS:

1. Discuss the pathophysiology of neonatal jaundice.
2. 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 to keep bilirubin levels down. Emphasize that breastmilk is the ideal food for infants.
3. Emphasize that parents should watch closely for jaundice and seek medical attention if jaundice is noticed. 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 medical personnel can check the level of bilirubin in the blood by blood tests or occasionally by a skin test.
5. Explain that mild jaundice is harmless but high levels of bilirubin may cause brain damage. 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. 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.

PP-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand some methods for treating the pain that may be associated with the postpartum period.

STANDARDS:

1. Discuss the proper use of any medications which have been prescribed.
2. Explain that increasing pain should prompt a visit or call to the patient's provider.
3. Discuss non-pharmacologic measures which may provide pain relief; sitz bath, massage, change of activity.

PP-WC WOUND CARE

OUTCOME: The patient/family will understand the necessity and procedure for proper wound care.

STANDARDS:

1. Explain the procedure, supplies and benefits of appropriate wound care.
2. Explain signs or symptoms that should prompt immediate follow-up, e.g., increasing redness, purulent discharge, fever, increased swelling/pain.
3. Emphasize the importance of follow-up.

PDEP - Postpartum Depression

PDEP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand postpartum depression and its symptoms.

STANDARDS:

1. Explain that postpartum depression is a type of mood disorder, a biological illness caused by changes in brain chemistry, and is not the mother's fault or the result of a weak or unstable personality. It is a medical illness which professional treatment can help.
2. Explain that postpartum depression occurs in up to 80% of women who give birth, and that it is treatable.
3. Review some of the biological, psychological/social factors related to the development of postpartum depression:
    a. Biological: Sudden drop in hormones after birth and/or changes in prolactin levels.
    b. Psychological/social: Stressful life events such as financial problems, housing problems, lack of family interaction and support, new mothers facing new roles, lack of sleep, increased responsibility, single mothering, and/or marital problems.
    c. Family or personal history of depression or mood disorders with or without pregnancy.
4. Discuss that postpartum depression is often not recognized by the mother or family. Emphasize the importance of discussing mood/behavior changes with a healthcare provider.
5. Describe the varying degrees of postpartum depression that may occur- Postpartum Blues, Postpartum Depression, and Postpartum Psychosis:
    a. **PP Blues**: Occurs first three days after birth lasting to a few weeks - tearfulness, irritability, mood swings, nervousness, feelings of vulnerability, trouble sleeping, loss of appetite, lack of confidence, and feeling overwhelmed.
    b. **PP Depression**: Occurs within first 3–6 months up to a year after birth - sadness, loss of interest in normal activities, inappropriate guilt, anxiety, fatigue, impaired concentration/ memory, over concern for baby or non at all, inability to cope, despondency/despair, thoughts of suicide, hopelessness, panic attacks (numbness, tingling in limbs, chest pain, hyperventilation, heart palpitations), feeling "like I'm going crazy," bizarre, or strange thoughts.
    c. **PP Psychosis:** Rarest and most severe form occurring in only 0.1% of women who have given birth – Extreme confusion, incoherence, rapid speech or

mania, refusal to eat, suspiciousness, irrational statements, agitation, hallucinations, or inability to stop an activity.

6. Explain that sometimes only a professional, through test interpretation, obtaining an appropriate history, and physical examination may be able to differentiate the degree of depression. Discuss the current knowledge of postpartum depression.
7. Emphasize that postpartum depression is reversible with early intervention and appropriate treatment. Refer as appropriate.

PDEP-FU FOLLOW-UP

OUTCOME: The patient/family will participate in the treatment plan and will understand the importance of full participation with medications and observations.

STANDARDS:

1. Emphasize the importance of keeping appointments for postpartum, well child and postpartum depression care.
2. Review treatment plan with the patient/family. Discuss the procedure for obtaining follow-up care, the importance of taking medications as prescribed, and how to recognize any functional impairments (as evidenced by the avoidance of family or friends, an inability to attend to hygiene, or an inability to care adequately for the infant). Explain that patients with coexisting with substance abuse may need more rapid referral.
3. Explain that if the patient has considered a plan to act on suicidal thoughts or has thoughts about harming her infant, this is a medical emergency and hospitalization may be necessary. Discuss the procedure for obtaining urgent and rapid referrals.

PDEP-L LITERATURE

OUTCOME: The patient/family will receive literature about Postpartum Depression.

STANDARDS:

1. Provide patient/family with literature on Postpartum Depression.
2. Discuss the content of the literature.

PDEP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adaptations necessary to decrease the risk for postpartum depression and maintain optimal health.

STANDARDS:

1. Advise that the patient may be able to decrease the risk for postpartum depression by preparing during the pregnancy for the changes in lifestyle that motherhood will bring.
2. Emphasize lifestyle adaptations that will help speed recovery from postpartum depression:
    a. Over-sleeping may be a symptom of depression but has also been shown to increase depressed feelings. Discourage remaining in bed or sleeping more than 8-hours a day.
    b. Advise that natural light and exercise have an antidepressant effect. Encourage the patient to exercise, for example take a walk out of doors for at least ½-hour between 11 AM and 2 PM to take care of the need for bright light and exercise.
    c. Emphasize the importance of TOTALLY abstaining from alcohol and recreational drugs. Alcohol and street drugs both induce depression and prevent antidepressants from working effectively. Advise your provider of all medications, drugs herbals and supplements you are taking to minimize this effect.
    d. Encourage the patient/family to accept the recommended help and assistance of others. There is no shame in asking for or accepting help.

PDEP-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
    a. Explain that many medications for postpartum depression do not exert an immediate effect and must be used regularly to be effective.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.
5. Explain that the patient's wish to breast-feed can be respected. The transfer of medication to the baby can be minimized by the mother breastfeeding before she takes her pills. Although many depression medications are excreted in breastmilk,

no cases of deleterious effects have been noted in infants to date. Refer the patient to a physician or pharmacist who is knowledgeable in the use of medications during breastfeeding for more specific information.

PDEP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of postpartum depression.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PDEP-N NUTRITION

OUTCOME: The patient/family will understand how diet relates to postpartum depression.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between diet and depression.
3. Explain that even marginal deficiencies in the diet will negatively affect the nervous system, mood and breastfeeding. A daily multivitamin and mineral supplement may be recommended to help ensure an adequate intake.
4. Assist in developing an appropriate diet plan. Refer to dietitian or other local resources as available. Stress the importance of eating on a regular schedule and eating a variety of foods.

PDEP-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in postpartum depression.

STANDARDS:

1. Explain that uncontrolled stress is attributed to an increase in severity of the symptoms of postpartum depression.
2. Explain that uncontrolled stress can interfere with the treatment of postpartum depression.
3. Explain that effective stress management may help reduce the severity of the symptoms of depression, as well as help improve the health and well-being of the patient.
4. Emphasize the importance of seeking professional help as needed to reduce stress.
5. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all of which can increase the severity of the depression or the risk of suicidal/homicidal behaviors.
6. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. Becoming aware of your own reactions to stress
    b. Recognizing and accepting your limits
    c. Recruiting other family members or friends to help with child care
    d. Talking with people you trust about your worries or problems
    e. Setting realistic goals
    f. Getting enough sleep (e.g., sleeping when the baby sleeps if possible)
    g. Maintaining a healthy diet
    h. Exercising regularly
    i. Taking vacations
    j. Practicing meditation, self-hypnosis, and positive imagery
    k. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    l. Participating in spiritual or cultural activities
7. Provide referrals as appropriate.

PDEP-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available based on the specific disease process, test results, severity of symptoms, the preferences of the patient, and the response to treatment during previous episodes.

STANDARDS:

1. Assist the patient/family in understanding that postpartum depression may require long-term intervention which may include psychotherapy, medication, support groups or electro-convulsive therapy.
2. Review the nature of postpartum depression as a treatable condition.
3. Explain that both the patient AND family may need to participate in the treatment to help understand the symptoms and cope with the increased stress on the family.
4. Assist the family in the realization that left untreated, postpartum depression can have significant negative effects on the baby that can persist into adulthood. It is therefore very important to identify and treat postpartum depression as early as possible.
5. Urge the family/patient to find someone to stay with and assist the patient at all times. Family and friends may offer support, reassurance, hope, and validation of the new mother's abilities.
6. Explain that treatment may begin at any point, even prior to pregnancy depending on the circumstance.

PDM - Prediabetes

PDM-C COMPLICATIONS

OUTCOME: The patient/family/caregiver will understand common or serious complications of abnormal fasting blood glucose level.

STANDARDS:

1. Explain that fasting blood glucose levels above 100 mg/dL but less than 126 mg/dL and 2 hour post prandial between 140-200 mg/dL are diagnostic of prediabetes and that prediabetes may progress to Type 2 Diabetes.
2. Emphasize that optimal control of blood glucose can reverse or prevent progression of PDM.
3. Emphasize that optimal control of blood glucose 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, e.g., heart attack, stroke. **Refer to** **"CVA - Cerebrovascular Disease" on page 159**, **"CAD - Coronary Artery Disease" on page 269**, **"DM - Diabetes Mellitus" on page 318**, and **"PVD - Peripheral Vascular Disease" on page 681**.
6. Discuss complications that can occur if PDM develops into Diabetes, e.g., heart disease, stroke, eye problems, kidney damage.

PDM-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving physical and behavioral health.

STANDARDS:

1. Discuss the roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to** **"AF-CON Confidentiality" on page 33**.

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, e.g., 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, that requires permanent lifestyle alterations and continuous attention and medical care. **Refer to "PDM-LA Lifestyle Adaptations" on page 715**.

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 the patient becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to "HPDP-EX Exercise" on page 480.**
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 Tests" on page 717.**

PDM-L LITERATURE

OUTCOME: The patient/family will receive literature about PDM.

STANDARDS:

1. Provide the patient/family with literature on PDM.
2. Discuss the content of the literature.

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 (e.g., heart attack, stroke) result from the higher than normal blood glucose levels and that the goal of management is to keep blood glucose as near to normal as possible.

PDM-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Explain that medical nutrition therapy and increased physical activity are the key components of blood glucose control and that medication(s) may be prescribed as an adjunct to help prevent or delay the onset of diabetes and its complications.
2. Describe the name, strength, purpose, dosing directions, and storage of the medication.

3. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
4. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
5. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

PDM-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of prediabetes.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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, e.g., 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, e.g., 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, e.g., 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.

PN - Prenatal

PN-1T FIRST TRIMESTER

OUTCOME: The first trimester patient will understand the progression of pregnancy as related to fetal growth/development and changes in her body.

STANDARDS:

1. Explain the reproductive cycle. Identify and explain the functions of: the ovaries, ova, fallopian tubes, uterus, cervix, placenta and vagina as they relate to pregnancy.
2. Discuss fetal growth and development during the first trimester. Explain the need for adequate folate intake before pregnancy and throughout the first trimester to help prevent fetal neural tube defects.
3. Emphasize the importance of complete abstinence from alcohol, tobacco, and other drugs. Point out that use of drugs and/or alcohol during pregnancy can result in birth defects or other complications. Evaluate the patient's use of substances and refer for treatment as appropriate. **Refer to "AOD - Alcohol and Other Drugs" on page 42.**
4. Teach the patient to inform all healthcare providers of the pregnancy prior to obtaining treatment, e.g., x-rays, medications.
5. Discuss the importance of good personal and dental hygiene as it relates to good health and positive self-image. **Refer to "HPDP-HY Hygiene" on page 481.**
6. Discuss the dangers of fetal overheating in relation to hot baths, jacuzzis, sweat lodges, heating pads, etc. Discuss the relief measures for the discomforts of pregnancy.
7. Discuss sex during pregnancy. Encourage the patient to ask questions.
8. Emphasize the patient's responsibilities to herself and her growing child. Emphasize the importance of regular prenatal care, rest, prescribed vitamins, iron, and good nutrition. Discuss the dangers of exposure to infectious diseases, e.g., measles, toxoplasmosis, STIs, parvovirus (5^{th} Disease).
9. Emphasize the importance and encourage enrollment in prepared childbirth and parenting classes.

PN-2T SECOND TRIMESTER

OUTCOME: The patient/family will understand the progression of pregnancy as related to fetal growth and development and changes in the body.

STANDARDS:

1. Discuss fetal growth and development in the second trimester.
2. Discuss the changes in the mother's body during the second trimester. Discuss exercise, rest, and relief measures for second trimester discomforts of pregnancy.
3. Encourage breastfeeding vs. bottle-feeding. Emphasize the advantages of breastfeeding for both mother and baby. **Refer to "BF - Breastfeeding" on page 135**.
4. Identify risks and warning signs for preterm labor (e.g., bleeding, cramping, unexplained abdominal pain).

PN-3T THIRD TRIMESTER

OUTCOME: The patient/family will understand the progression of pregnancy as related to fetal growth and development and changes in the body.

STANDARDS:

1. Discuss changes in the mother's body during the third trimester. Discuss exercise, rest, and relief measures for third trimester discomforts of pregnancy.
2. Discuss the anatomy and physiology of lactation and care of the breasts and nipples **Refer to "BF - Breastfeeding" on page 135.**
3. Discuss sex during the late stages of pregnancy and early postpartum period. Discuss methods of contraception. Emphasize the importance of partner participation in family planning.
4. Discuss the signs of impending labor. Discuss those events that require immediate attention, e g., ruptured membranes, bleeding, fever. Emphasize the importance of knowing "when you are in labor" and when to seek medical attention.
5. Discuss the three stages of labor. Discuss the possibility of a C-section. Review breathing exercises for labor. If feasible, refer the patient for childbirth education classes.
6. Discuss the hospital admission routines, e.g. fetal monitoring, IVs, induction.
7. Explain that a bacteria called *Group B strep* may be dangerous to the baby and explain the institution's screening procedure.
8. **Refer to "CB-PRO Procedures, Obstetrical" on page 237**.

PN-ADM ADMISSION

OUTCOME: The patient/family will understand the hospital admission process for delivery.

STANDARDS:

1. Discuss preparations for preadmission, as appropriate:
   a. What paper work to do in advance.
   b. When to come to the hospital.
   c. What to bring to the hospital.
   d. Where to go for admission. This may include a hospital tour.
   e. What to expect on admission.

PN-AOD ALCOHOL AND OTHER DRUGS

OUTCOME: The patient/family will understand the disease process of chemical dependency/substance abuse and its relationship to fetal development.

STANDARDS:

1. Emphasize the importance of complete abstinence from alcohol, inhalants, other drugs, and tobacco because they are associated with birth defects and other complications. Evaluate the patient's use of substances and refer for treatment as appropriate. **Refer to "AOD - Alcohol and Other Drugs" on page 42** and/or **"TO - Tobacco Use" on page 828.**
2. Discuss that alcohol use during pregnancy is directly associated with an identifiable syndrome in the child. This syndrome can cause developmental delay, hyperactivity, emotional and behavioral problems, mental retardation, learning disabilities, and decreased ability to function independently as an adult. **Refer to "FAS - Fetal Alcohol Syndrome" on page 394**.
3. Refer to community resources as available or appropriate.

PN-BH BEHAVIORAL HEALTH

OUTCOME: The patient/family will understand some of the mental and emotional changes that may take place during and after pregnancy.

STANDARDS:

1. Discuss that pregnancy is a state of hormonal flux and may result in rapid and unpredictable mood swings.
2. Discuss any pre-existing mental or emotional health conditions in the patient or the patient's family.
3. Explain that although some emotional changes may be normal, others may require medication and/or other forms of treatment.

4. Discuss the signs and symptoms of post-partum depression. **Refer to "PDEP - Postpartum Depression" on page 707**.
5. Refer to mental health or other resources as appropriate.
6. Explain that breastfeeding in the postpartum period may result in a more rapid return to pre-pregnancy weight.

PN-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications of pregnancy and the appropriate action to take.

STANDARDS:

1. Discuss the symptoms of pre-term labor. Emphasize the importance of immediate evaluation by a physician for pre-term labor. Explain that immediate treatment may decrease but not eliminate the risk of neonatal death or lost pregnancy.
2. Explain that any bleeding as heavy as a period should prompt an immediate evaluation by a physician. Explain that this bleeding may be an early sign of miscarriage.
3. Explain that decreased fetal movement in the third trimester should prompt an immediate evaluation.
4. Emphasize to the patient that pregnancy induced hypertension may be asymptomatic or may be accompanied by warning signs (persistent swelling, persistent headaches, visual changes, decreased fetal movement, sudden weight gain, nausea, and vomiting in the third trimester). Stress that immediate medical attention should be sought if warning signs occur. **Refer to "PN-PIH Pregnancy-Induced Hypertension And Pre-Eclampsia" on page 727.**

PN-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. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.

3. 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.
4. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PN-DC DENTAL CARIES

OUTCOME: The patient/family will understand how maternal oral hygiene and diet affect dental conditions in the mother and infant.

STANDARDS:

1. Explain that tooth decay (dental caries) is partially caused by bacteria in the mouth.
   a. Explain that this bacteria can be transmitted from the mother to the infant. Emphasize the importance of never putting bottle nipples, pacifiers, or any feeding utensils in any mouth except the infant's mouth.
   b. Emphasize the importance of the prenatal patient having a dental exam and treating dental caries before the birth of the infant.
2. Discuss the importance of oral hygiene for the infant and the mother. **Refer to "DC-P Prevention" on page 309.**
3. Discuss the necessity of adequate calcium in the diet of prenatal patients to prevent calcium loss from bones and teeth.

PN-DV DOMESTIC VIOLENCE

OUTCOME: The patient/family will understand that domestic violence is a primary, chronic, and preventable disorder.

STANDARDS:

1. Discuss abusive/violent behaviors in the patient's environment.
2. Explain co-dependency as it relates to domestic violence.
3. Identify risk factors and "red flag" behaviors related to domestic violence, e.g., belittling, demeaning, humiliating behaviors.
4. Discuss the role of alcohol and substance abuse as it relates to domestic violence.
5. Explain that the natural course of domestic violence is one of escalation and that without intervention it will not resolve.
6. Discuss the availabilities of shelters and other support options available in the patient's area. Make referrals as appropriate.

7. Assist to develop a plan of action which will ensure safety of all people in the environment of violence.

PN-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate (when appropriate) the proper use and care of home medical equipment.

STANDARDS:

1. Discuss indications for and benefits of prescribed home medical equipment.
2. Discuss the types and the features of home medical equipment as appropriate.
3. Discuss and/or demonstrate the 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, e.g., electrical cord safety, and disposal of sharps.

PN-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity during pregnancy.

STANDARDS:

1. Review the basic recommendations/benefits of physical activity during pregnancy.
2. Explain that hormonal changes during pregnancy result in increased elasticity of tendons and may increase the risk of joint injuries.
3. Explain that, in general, a pregnant patient can maintain her previous level of physical activity but should contact her provider for specific instructions. Discuss any physical activities that are contraindicated.
4. Review appropriate exercise programs available in the community.

PN-FAS FETAL ALCOHOL SYNDROME

OUTCOME: The patient/family will understand the consequences of alcohol use during pregnancy.

STANDARDS:

1. Discuss that consumption of any amount of alcohol during pregnancy can cause FAS or FASD. **Refer to "FAS - Fetal Alcohol Syndrome" on page 394**.

2. Emphasize the importance of abstinence from any alcohol use during pregnancy (including beer, wine, liquor, and wine coolers).
3. Discuss available treatment or intervention options, as appropriate.

PN-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in prenatal care.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

PN-GD GROWTH AND DEVELOPMENT

OUTCOME: The patient/family will understand the unborn infant's growth and development.

STANDARDS:

1. Explain the conception process, the implantation, and the cell division, as appropriate. Discuss the functions of the placenta, the amniotic sac, and umbilical cord, as appropriate.
2. Give a basic overview of the unborn infant's growth and development.

PN-GDM GESTATIONAL DIABETES

OUTCOME: The patient/family will understand diabetes or carbohydrate intolerance during pregnancy and will establish a plan for control.

STANDARDS:

1. Discuss the management and careful monitoring of blood glucose.
2. Emphasize the need for an individualized meal plan by a registered dietitian.
3. Discuss that GDM increases the risk for developing Type 2 Diabetes. Discuss the effect of gestational diabetes on the infant (hypoglycemia in the early neonatal

period, respiratory distress, complications of delivery, increased incidence of obesity and future development of Type 2 diabetes.).

4. Emphasize that prenatal care for future pregnancies should begin prior to conception for early monitoring of GDM.
5. Explain that blood glucose control may be more difficult to obtain in the third trimester due to hormonal changes that elevate blood glucose and that insulin may be needed. Emphasize the need for follow-up care in the post partum period to monitor blood glucose as recommended.

PN-GENE GENETIC TESTING

OUTCOME: The patient/family will understand that some diseases or conditions are inherited and that testing may be recommended.

STANDARDS:

1. Explain that some diseases or birth defects can be detected during pregnancy and tests that may be performed (e.g., ultrasound, blood tests, amniocentesis). Discuss the timing of the tests as appropriate.
2. Explain that not all patients are at equal risk for these conditions.
3. Refer appropriate patients to a physician or other provider for further evaluation.

PN-HIV HUMAN IMMUNODEFICIENCY VIRUS

OUTCOME: The patient/family will understand risk factors for HIV (mother and child).

STANDARDS:

1. Discuss risk factors and indications for HIV testing (mother and child).
2. Explain that early detection, early treatment, and full participation with the medication regimen as well as maintaining a healthy lifestyle can result in a better quality of life, slow the progression of the disease, and may have beneficial effects upon the delivery and longevity of the child.

PN-L LITERATURE

OUTCOME: The patient/family will receive literature about prenatal issues.

STANDARDS:

1. Provide the patient/family with literature on prenatal issues.
2. Discuss the content of the literature.

PN-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

PN-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for the treatment or management of prenatal care.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PN-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition in pregnancy as related to maternal health as well as fetal growth and development.

STANDARDS:

1. Explain the purpose of appropriate weight gain in pregnancy. Explain the actions to correct constipation, nausea, vomiting, or pica.
2. Encourage adequate calcium intake and calcium sources (e.g., milk products, calcium supplements). **Refer to** **"OS-N Nutrition" on page 643**for other sources of calcium.
3. Explain the benefits of healthy eating habits. Explain that certain types of fish should be limited due to the risk of contamination (e.g., salmon, mackerel, tuna, sword fish).
4. Encourage a limited intake of artificial sweeteners and other foods or beverages sweetened by these products.
5. Encourage liberal intake of water.
6. Discuss supplemental food programs (e.g., WIC, food distribution/commodity programs, food stamps).
7. Refer patients with GDM to a registered dietitian for an individualized meal plan.

PN-PIH PREGNANCY-INDUCED HYPERTENSION AND PRE-ECLAMPSIA

OUTCOME: The patient/family will understand the risk, symptoms, and treatment of pregnancy-induced hypertension and preeclampsia.

STANDARDS:

1. Explain the difference between systolic and diastolic blood pressure. Define normal ranges for the individual. Review predisposing factors for hypertension (e.g., obesity, high sodium intake, high fat and cholesterol intake, lack of exercise).
2. Discuss pregnancy as a contributing factor to hypertension - either by worsening existing hypertension or by the new onset of preeclampsia.
3. Emphasize that PIH may be asymptomatic or may be accompanied by warning signs (persistent swelling, persistent headaches, visual changes, decreased fetal movement, sudden weight gain, nausea, and vomiting in the third trimester.) Stress that medical attention should be sought immediately if warning signs occur.
4. Discuss the complications, e.g., seizures, maternal/fetal brain injury or death and premature birth.
5. Discuss that the healthcare provider may prescribe bed rest.

PN-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand some techniques for reducing discomfort during pregnancy.

STANDARDS:

1. Explain that headaches, abdominal and back discomfort, and other discomforts are common and expected in pregnancy.
2. Discuss measures that may relieve pain, e.g., warm bath, change of activity, massage.
3. Explain that most pain medications including NSAIDs should not be used in pregnancy, but that the patient's provider can recommend and/or prescribe pain medication if necessary.

PN-PTL PRE-TERM LABOR

OUTCOME: The patient/family will understand and identify risks and warning signs of pre-term labor.

STANDARDS:

1. Explain that preterm labor may not feel the same as term labor.
2. Emphasize the importance of seeking immediate medical attention for any abnormal sensations/symptoms especially if they occur at regular interval (e.g., bleeding, cramping, backache, unexplained abdominal pain).
3. Explain that early medical intervention may prevent preterm birth.
4. Explain that the healthcare provider may prescribe bed rest.

PN-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand safety measures specific to pregnancy.

STANDARDS:

1. Discuss the regular use of seat belts, children's car seats and obeying the speed limit. Discuss that seatbelts should be worn low on the hips and the shoulder belt should lie above the pregnant abdomen.
2. Discuss the dangers of fetal overheating in relation to hot baths, Jacuzzis, sweat lodges, heating pads, etc.
3. **Refer to "HPDP-S Safety and Injury Prevention" on page 483** as appropriate.

PN-SHS SECOND-HAND SMOKE

OUTCOME: The patient/family will understand the adverse health consequences associated with exposure to second-hand tobacco smoke.

STANDARDS:

1. Define "passive smoking" and ways in which exposure occurs, e.g., smoldering tobacco, exhaled smoke, residue in carpet.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, CO, carcinogens.
3. Explain the increased risk of illness in children and adults when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia, lung cancer.
4. Emphasize that the infants who are exposed to smoke in the home are three times more likely to die of SIDS than infants who live in a non-smoker's home.
5. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing still increases the risk of illness.
6. Discuss that having household members smoke outside and removing smoke contaminated clothing may decrease exposure to second hand smoke.
7. Encourage smoking cessation or at least never smoking in the home or car. **Refer to "TO-QT Quit" on page 832.**

PN-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in overall health and well-being.

STANDARDS:

1. Explain that uncontrolled stress may cause release of stress hormones that interfere with general health and well-being. Explain that effective stress management may help the patient have a more positive experience with pregnancy and childbirth.
2. Discuss that stress may exacerbate adverse health behaviors such as tobacco, alcohol, or other substance use as well as inappropriate eating all of which have been shown to have an adverse effect on the developing baby. Emphasize the importance of seeking professional help as needed to reduce stress.
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 healthy diet
   g. Exercising regularly

h. Taking vacations

i. Practicing meditation, self-hypnosis, and positive imagery

j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation

k. Participating in spiritual or cultural activities

4. Provide referrals as appropriate.

PN-SOC SOCIAL HEALTH

OUTCOME: The patient/family will understand social services available.

STANDARDS:

1. Discuss the patient's living situation including access to adequate housing, electricity, refrigeration, sanitation, running water, and adequate and nutritional foods.
2. Discuss the patient's access to transportation. Refer to community resources as available.
3. Discuss the patient's eligibility for state, federal, or tribal resource programs, e.g., WIC, state Medicaid, food stamps, commodities, housing assistance. Emphasize that IHS and/or ITU programs may not be able to meet all of the patient's needs; therefore, she should apply for all programs for which she may be eligible.
4. Discuss adoption, abortion, miscarriage, as appropriate. Refer to Community Resources, Behavioral Health, and/or Social Services as appropriate.

PN-STI SEXUALLY TRANSMITTED INFECTIONS (FORMERLY STD)

OUTCOME: The patient/partner will understand risk factors, transmission, symptoms, and complications.

STANDARDS

1. Discuss specific STIs and how they are transmitted, e.g., semen, vaginal fluids, blood, mother to infant during pregnancy, child birth, or breastfeeding.
2. Explain how STIs cannot be transmitted, e.g., casual contact, toilet seats, eating utensils, coughing.
3. Discuss that STIs may be curable or incurable STIs. Stress the importance of prevention and early treatment.
4. Explain that infection is dependent upon behavior, not on race, age, or social status.

5. Review the actions to take when exposed to an STI and complications that may result if not treated including complications in the unborn child.
6. **Refer to "STI - Sexually Transmitted Infections" on page 786** and **"HIV - Human Immunodeficiency Virus" on page 506** as appropriate.

PN-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 preparation
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 the meaning of the test results, as appropriate.

PN-TO TOBACCO

OUTCOME: The patient/family will understand the dangers of tobacco or nicotine use during pregnancy.

STANDARDS:

1. Review the current information regarding tobacco use. Discuss the dangers of tobacco use during pregnancy. These include:
   a. Low birth weight infants
   b. Intrauterine growth retardation
   c. Nicotine withdrawal in the newborn
   d. Increased incidence of asthma and pneumonia in the child
   e. Spontaneous abortion or miscarriage
   f. Placental insufficiency
2. Explain nicotine addiction and the common problems associated with tobacco use. The long term effects of continued tobacco use include COPD, cardiovascular disease, and numerous kinds of cancers including lung cancer.
3. Review the effects of tobacco use on all family members e.g., financial burden, second-hand smoke, greater risk of fire, and premature death of a parent.
4. Explain dependency and co-dependency as it relates to addictive behavior.

5. Discuss that smoking is a serious threat to health. Encourage tobacco cessation. **Refer to "TO - Tobacco Use" on page 828**.

PN-VBAC VAGINAL BIRTH AFTER CESAREAN SECTION

OUTCOME: The patient/labor partner/family will understand that VBAC is possible, as well as the processes, risks, and benefits associated with VBAC.

STANDARDS

1. Discuss the success rate of VBAC. Explain the importance of having prior medical records to determine whether the patient is a candidate for VBAC. Discuss that there is a faster recovery after VBAC than a repeat C-section.
2. Explain that close monitoring of the labor process will be necessary and that if complications arise a C-section may be necessary.
3. Explain that significant risks from VBAC include uterine rupture, failure to progress in labor, and C-section.

PU - Pressure Ulcers

PU-C COMPLICATIONS

OUTCOME: Patient/family will have an understanding of the potential complications of pressure ulcers.

STANDARDS:

1. Discuss the common and important complications of pressure ulcers, e.g. wound infection, high fever, sepsis.
2. Discuss the importance of following a treatment plan to decrease/eliminate the complications of pressure ulcers.
3. Emphasize the importance of medical intervention for signs and symptoms of complications.

PU-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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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.

PU-DP DISEASE PROCESS

OUTCOME: The patient/family will have an understanding of what pressure ulcers are and factors that are associated with increased risk of pressure ulcers.

STANDARDS:

1. Explain that a pressure ulcer is a lesion caused by unrelieved pressure resulting in damage of underlying tissue. These may be located over bony prominences or under a medical device/equipment.
2. Explain that a pressure ulcer may range from a red spot with intact skin to a large, deep open lesion.
3. Review the factors related to the development of pressure ulcers – decreased sensory perception, skin moisture, bedrest, immobility, poor nutrition and skin friction/shear.
4. Explain that the first sign of a pressure ulcer is a reddened area that does not blanch that is over a bony prominence or under equipment.
5. Explain that if pressure on the skin is not relieved, the pressure ulcer will increase in size and depth, will not heal, and poses a risk to infection.

PU-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate, as 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.

PU-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of adhering to the treatment plan and keeping appointments for follow-up.

STANDARDS:

1. Discuss the individual's/family's/caregiver's responsibility in the management of pressure ulcers.
2. Discuss the importance of follow-up care.
3. Explain the procedure for obtaining follow-up appointments.
4. Emphasize the importance of keeping follow-up appointments.
5. Explain signs and symptoms that would prompt immediate follow-up, e.g., high fever, increased redness, purulent discharge, increased swelling, pain.

PU-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand what lifestyle adaptations are necessary to cope with the patient's specific disorder and how diet and activity will interact with anticoagulation therapy.

STANDARDS:

1. Assess the patient/family's level of acceptance of the disorder.
2. Emphasize the importance of avoiding dangerous or hazardous activities while receiving anticoagulation therapy.
3. Review the areas that may require adaptations, e.g., diet and physical activity.

PU-L LITERATURE

OUTCOME: The patient/family will receive literature about pressure ulcers.

STANDARDS:

1. Provide the patient/family with literature about pressure ulcers.
2. Discuss the content of the literature.

PU-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.

3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

PU-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for the treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PU-N NUTRITION

OUTCOME: Parents/Family will have an understanding of the importance of proper nutrition in preventing and treating pressure ulcers.

STANDARDS:

1. Explain the importance of adequate nutrition and hydration in the repair of tissue.
2. Explain that, generally, protein intake should be increased to facilitate tissue health and carbohydrate intake should be increased to spare proteins.

PU-P PREVENTION

OUTCOME: The patient and/or family will understand the factors associated with an increased risk of pressure ulcers and how to lower the risk of pressure ulcers and prevent problems.

STANDARDS

1. Explain that frequent position changes to relieve the pressure on the tissues over bony prominences are necessary to maintain circulation to tissues.
2. Explain that the heels are particularly prone to breakdown for patients who lay in bed and commercial heel protectors may reduce pressure.
3. As indicated, explain the role of special beds/mattresses that have pressure reducing surfaces in the prevention of pressure ulcers.
4. Instruct family not to massage reddened skin over bony prominences. This does not increase circulation and can further damage tissue.
5. For patients at high risk for pressure ulcers, explain that elevating the head of the bed over 30 degrees increases the chance of skin shear.
6. As appropriate, discuss the role of skin moisture in skin breakdown and the use of absorbent pads to wick moisture from the skin or commercial moisture barriers to keep moisture from the skin.
7. Explain the importance of adequate nutrition and hydration in the prevention of skin breakdown. Generally, protein intake should be increased and carbohydrate intake should be increased to spare proteins. **Refer to "PU-N Nutrition" on page 736**.

PU-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 - Pain Management" on page 657.**
2. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain or nausea and vomiting.
3. Explain non-pharmacologic measures that may be helpful with pain control.

PU-PRO PROCEDURES

OUTCOME: The patient and/or family will have an understanding of the possible procedure(s) that may be performed to treat the pressure ulcer. The patient/family will

further have an understanding of the risks and benefits of the procedure, the alternatives to the proposed procedure, and the risks of refusal of the proposed procedure.

STANDARDS:

1. As applicable, list the possible procedures that might be utilized to treat the pressure ulcer.
2. Briefly explain each of the possible procedures.
3. Explain that the treatment decision will be made by the patient and medical team after reviewing the results of diagnostic tests, as applicable.
4. Discuss the risks and benefits of the proposed procedure. Discuss the risk of not attempting the procedure.

PU-SCR SCREENING

OUTCOME: The patient/family will have an understanding of the reason and process for screening for pressure ulcer risk.

STANDARDS:

1. Explain that the reason for the pressure ulcer risk screening is for the implementation of appropriate interventions to decrease the risk of pressure ulcers.
2. Explain that the purpose of screening for pressure ulcers is to identify the ulcers at the earliest stages and initiate early treatment to prevent progression.
3. Explain that factors associated with an increased risk of pressure ulcers are assessed at intervals prescribed by hospital policy if the patient is an inpatient.
4. Discuss the factors that are assessed as part of the screening process. These may include, but are not limited to impaired sensory perception, skin moisture, decreased activity, decreased mobility, impaired nutrition, and skin friction and shear.

PU-TE TESTS

OUTCOME: The patient and/or family will have a basic understanding of the test(s) to be performed, including the indications and impact on diagnose and further care of pressure ulcers.

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.

PU-TX TREATMENT

OUTCOME: The patient and/or family will have an understanding of the possible treatments they may be performed based on the test results. The patient/family will further have an understanding of the risks and benefits of the treatment alternatives to the proposed treatment and the risks of refusal of the proposed treatment.

STANDARDS:

1. List the possible treatments that might be utilized to treat/prevent pressure ulcers.
2. Briefly explain each of the possible treatments.
3. Explain that the treatment decision will be made by the patient and medical team after reviewing the results of diagnostic tests, as applicable.
4. Discuss the risks and benefits of the proposed treatment. Discuss the risk of non-treatment.

PU-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, e.g., 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. As appropriate, 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.

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, e.g., 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 in the treatment of psoriasis.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

PSR-L LITERATURE

OUTCOME: The patient/family will receive literature about psoriasis.

STANDARDS:

1. Provide patient/family with information on psoriasis
2. Discuss the content of the literature.

PSR-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARD:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.

4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

PSR-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of psoriasis.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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, e.g., 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 Stress Management" on page 744.**

PSR-SM STRESS MANAGEMENT

OUTCOME: 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:
   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 healthy diet
   g. Exercising regularly
   h. Taking vacations
   i. Practicing meditation, self-hypnosis, and positive imagery
   j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   k. Participating in 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 many treatments for psoriasis are available. Patient may not respond one treatment but will respond to another one.
2. 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.
3. Explain that topical ointments include salicylic acid ointments, steroid-based creams, and other medications, e.g., calcipotriene, which is related to vitamin D.
4. Explain that coal-tar ointments and shampoos can alleviate symptoms but these may also cause side effects, such as folliculitis.
5. 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.
6. 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-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family/caregiver will understand the process of developing an advance directive and its role in maintaining a sense of control in the patient's medical care and decisions.

STANDARDS:

1. Explain that patients may lose the ability to make their own decisions and an advance directive will be able to express the patient's desires prior to the loss of decision-making abilities.
2. Review the option of Advanced Directives/Living Will with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
3. Refer to appropriate services to assist the patient in making a living will, e.g., Social Services, Clergy, Lawyer.
4. **Refer to "ADV - Advance Directives" on page 40**.

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 (e.g., 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.
3. Stress the importance of fully participating in the treatment plan.

PL-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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 the 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 the 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. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Discuss obstacles to a personal exercise plan and solutions to those obstacles. Assist the patient in developing a personal exercise plan.
4. Encourage the patient to increase the intensity and duration of the activity as the patient becomes more fit.
5. Refer to community resources as appropriate.

PL-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of pulmonary disease.

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 the 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, e.g., 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 LITERATURE

OUTCOME: The patient/family will receive literature about pulmonary disease.

STANDARDS:

1. Provide the patient/family with literature on pulmonary disease.
2. Discuss the content of the literature.

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 (e.g., 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/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss the difference between bronchodilator and anti-inflammatory (e.g., short acting relieve and long acting controller) medications.
4. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
5. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

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-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of pulmonary disease.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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 "HPDP-N Nutrition" on page 483**.
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, e.g., cigarettes, sparks, flames.
2. Emphasize the importance of regular maintenance checks of oxygen equipment.
3. Emphasize that O_2 flow rate should not be changed except upon the order of a physician, since altering the flow rate may worsen the condition.
4. Discuss the use, the care, and the 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 - Pain Management" on page 657.**
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, e.g., smoldering cigarette, cigar, or pipe, smoke that is exhaled from active smoker, smoke residue on clothing, upholstery, carpets, or walls.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, and 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 the 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 and collection method.
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 and instructions for the test.
5. Explain the meaning of the test results, as appropriate.

PL-TO TOBACCO (SMOKING)

OUTCOME: The patient/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 - Tobacco Use" on page 828.**

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-EQ EQUIPMENT

OUTCOME: The patient/family will understand the role of equipment used during the procedure.

STANDARDS:

1. Discuss the use of personal protective equipment (e.g., lead shields, gloves) and their role in preventing transmission of disease and unnecessary radiation exposure.
2. Demonstrate the proper use of equipment to be used.
3. Explain that certain positioning of patient/equipment may be required for imaging, as appropriate.
4. Explain that some procedures may require chaperones.

XRAY-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in radiology/nuclear medicine.

STANDARDS:

1. Discuss the findings that will signify a serious complication or condition.
2. Discuss the procedure for obtaining test results and follow-up appointments.
3. Explain that certain procedures may require immediate follow-up.

XRAY-L LITERATURE

OUTCOME: The patient/family will receive literature about radiology/nuclear medicine.

STANDARDS:

1. Provide patient/family with literature on radiology/nuclear medicine.
2. Discuss the content of the literature.

XRAY-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

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, e.g., bowel prep, diet instructions, bathing.
5. Discuss pain management as appropriate.
6. Emphasize post-procedure management and follow-up.

XRAY-S SAFETY

OUTCOME: The patient/family will understand the safety procedures used to protect the patient and staff and will discuss the importance of correctly identifying self to the provider.

STANDARDS:

1. Discuss the importance of informing the providers of pregnancy status in females of childbearing age prior to procedures.
2. Discuss the importance of informing the providers of any allergies, e.g., latex, iodine dye, and medications.
3. Explain the importance of correctly identifying self before the procedure, e.g., name, birth date.
4. Discuss as appropriate that needles and other infusion equipment are single-patient use and will be discarded.
5. Discuss the procedure for accidental needle-stick of the patient or the staff as appropriate.

XRAY-SCR SCREENING

OUTCOME: The patient/family will understand that some tests for screening and not for diagnostic purposes.

STANDARDS:

1. Discuss that screening tests are used to screen for a wide variety of diseases and conditions, reduce radiation exposure, and reduce the need for more complicated tests.
2. Explain that further testing may be required and other preparations may be required to complete testing.

XRAY-TE TESTS

OUTCOME: The patient/family will understand the test to be performed, including indications and its impact on further care.

STANDARDS:

1. Explain the test that has been ordered and method of imaging, e.g., MRI, CT scan, ultrasound, EKG, etc.
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 and instructions for the test, e.g., fasting.
4. Explain the procedure for obtaining test results.

5. Explain the test results, as appropriate.

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 to 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 two 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 in the treatment of RSV.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer 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 LITERATURE

OUTCOME: The patient/family will receive literature about RSV.

STANDARDS:

1. Provide the patient/family with literature on RSV.
2. Discuss the content of the literature.

RSV-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

RSV-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of RSV.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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 (e.g., 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/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, e.g., smoldering cigarette, cigar, or pipe, smoke that is exhaled from active smoker, smoke residue on clothing, upholstery, carpets or walls.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, and 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 and collection method, e.g., 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.

RST - Restraints

RST-EQ EQUIPMENT

OUTCOME: The patient/family will be instructed on the type of restraint used.

STANDARDS:

1. Explain the hospital policy and procedure to the patient/family.
2. Explain that use of restraint is a last resort and is required to improve the patient's safety and well-being and other less restrictive measures have been found to be ineffective to protect the patient from harm.
3. Explain the alternative interventions that were attempted but proved ineffective prior to the use of a physical restraint, e.g., frequent reorientation, position change, modify environment, modifying behavior, scheduled toileting, pain/comfort measures, places closer to nurse's desk, fall risk assessment, encourage family to stay, or there may be no appropriate intervention.
4. Explain the type of restraint to be used on the patient (waist, vest, wrists, ankles, or leather restraints).
5. Explain that nursing assessments will be completed as the hospital policy dictates.
6. Explain to the patient/family the necessary conditions for early release from restraints.

RST-L LITERATURE

OUTCOME: The patient/family will receive literature about the clinical justification necessitating the restraint of the patient.

STANDARDS:

1. Provide patient/family with restraint literature.
2. Discuss the content of the literature.

RST-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.

2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

RST-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand possible safety risks and inform the nursing staff immediately if the patient seems compromised.

STANDARDS:

1. Explain common and important safety risks associated with the type of restraint being used.
2. Explain the importance of not tampering with restraint devices or releasing the patient without informing staff.
3. Emphasize to the patient/family/caregiver the importance of immediately reporting any concern or adverse effect of the restraint, e.g., cold or blue limbs, restraints around the neck, patient slipping down in the bed.
4. Explain that the patient will need assistance with nutritional, range of motion, hygiene, and elimination needs.

RA - Rheumatoid Arthritis

RA-C COMPLICATIONS

OUTCOME: The patient/family/caregiver will understand common complications of rheumatoid arthritis and their management.

STANDARDS:

1. Explain that rheumatoid arthritis is a chronic disease that worsens over time. The patient may experience symptom-free days and periods of worsening symptoms.
2. Review the common complications associated with rheumatoid arthritis, e.g., infection, renal disease, lymphoproliferative disorders, and cardiovascular disease.
3. Review the treatment plan with the patient. Explain that complications are worsened by not participating with the treatment plan.

RA-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

RA-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of rheumatoid arthritis.

STANDARDS:

1. Review the disease process of rheumatoid arthritis.
2. Review the physical limitation that may be imposed by rheumatoid arthritis.
3. Explain that treatments are highly individualized and may vary over the course of the disease.

4. Refer to the Arthritis Foundation or community resources as appropriate.

RA-EQ EQUIPMENT

OUTCOME: The patient/family/caregiver will have an understanding and will demonstrate (when appropriate) the proper use and care of assisted medical devices/ equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss the types and the features of the assisted medical devices/equipment as appropriate.
3. Discuss and/or demonstrate the proper use, care, and cleaning of assisted medical devices/equipment.
4. Explain that the patient/family/caregiver will demonstrate the proper use of the assisted medical devices/equipment.
5. Discuss the signs of assisted medical devices/equipment malfunction and the proper action in case of malfunction as appropriate.

RA-EX EXERCISE

OUTCOME: The patient will maintain an optimal level of mobility with minimal discomfort.

STANDARDS:

1. Emphasize that exercise is an important component of the treatment plan. Stress the importance of balancing rest and exercise.
2. Explain that exercise, when done correctly, can help reduce rheumatoid arthritis symptoms, including the following:
    a. Preventing joint stiffness
    b. Keeping muscles strong around the joints
    c. Improving joint flexibility
    d. Reducing pain
    e. Maintaining strong and healthy bone and cartilage tissue
    f. Improving joint alignment
    g. Improving overall fitness
3. Emphasize that exercise can also help with weight reduction and contributes to an improved sense of well-being, enhance sleep, and reduce stress and depression.

4. Review the different types of exercises including active and passive range of motion, muscle strengthening, and endurance exercises, e.g., water exercises, hot tubs.
5. If applicable, review and demonstrate the prescribed exercise plan.
6. Emphasize the importance of "warm-ups and cool-downs." Explain how the application of heat or cold prior to beginning exercise may reduce joint discomfort. Explain that people who have poor circulation should talk to their healthcare provider before using hot or ice packs.
7. Caution the patient not to overexert. Stress the importance of taking a break when experiencing pain or fatigue. Explain the signs and symptoms of when to discontinue exercising, e.g., chest pain, shortness of breath, or joint pain.

RA-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of rheumatoid arthritis.

STANDARDS:

1. Discuss the patient's responsibility in managing rheumatoid arthritis.
2. Review treatment plan with the patient/family, emphasizing the need for keeping appointments and adhering to medications regimens.

RA-L LITERATURE

OUTCOME: The patient/family will receive literature about rheumatoid arthritis.

STANDARDS:

1. Provide the patient/family with literature on rheumatoid arthritis.
2. Discuss the content of the literature.

RA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle changes necessary to optimize performance of everyday activities.

STANDARDS:

1. Discuss that treatment for arthritis is usually a combination of rest and relaxation, exercise, proper diet, medication, joint protection, and ways to conserve energy. Discuss way to pain management. **Refer to "RA-PM Pain Management" on page 772**.
2. Review activity limitation and the importance of avoiding fatigue.

3. Discuss ADL aids. Make a referral to social services for assistance in procuring such devices.
4. Explain how exercise and social involvement may decrease the depression and anger often associated with rheumatoid arthritis.
5. Discuss how self-image, pain, fatigue, inflammation, limited joint mobility, and medications can alter sexual desire and sexual activity.
6. Assess level of acceptance and offer support and referral to social services and community resources as appropriate.
7. Discuss the importance of relaxation to minimize stress, thus minimizing symptoms. A relaxed body means the muscles are relaxed, relieving some of the pain associated with rheumatoid arthritis.
8. Discuss the techniques that may reduce stress and depression such as meditation, imagery, prayer, hypnosis, and biofeedback.
9. **Refer to "HPDP - Health Promotion Disease Prevention" on page 479.**

RA-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.
5. Explain that rheumatoid arthritis is chronic, making long-term management of pain and symptoms of the disease very important.

RA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of rheumatoid arthritis.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

RA-N NUTRITION

OUTCOME: The patient will strive to achieve and maintain a safe weight level through a nutritionally balanced diet.

STANDARDS:

1. Assess the patient's current nutritional patterns and review improvements which can be made. **Refer to "HPDP-N Nutrition" on page 483.**
2. Explain that a well-balanced diet helps to manage body weight and provides the body with the nutrients it needs to stay healthy.
3. Refer to a registered dietitian.

RA-PM PAIN MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the patient's pain management program.

STANDARDS:

1. Stress the need to fully participate with the prescribed treatment plan, which may include chronic pain management.
2. Emphasize the importance of rest and the avoidance of fatigue.
3. Discuss the use of heat and cold.
4. Discuss the techniques that may reduce stress and depression such as meditation and bio-feedback.

5. Emphasize the role of exercise in reducing pain, maximizing mobility, and reducing stress/anxiety.
6. Refer to physical therapy as appropriate.

RA-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family/caregiver will understand the importance of injury prevention and implement necessary measures to avoid injury.

STANDARDS:

1. Explain the importance of body mechanics and proper lifting techniques in relation to physical limitations to avoid injury.
2. Explain ways to adapt the home to improve safety and prevent injuries, such as return throw rugs, install safety bars in hallways and near stairs.
3. Stress the importance and proper use mobility devices (cane, walker, electric scooters, wheel chair).
4. Explain the importance of recognizing driving limitations. Refer to the community resources.

RA-SM STRESS MANAGEMENT

OUTCOME: The patient/family/caregiver will role of stress management in rheumatoid arthritis.

STANDARDS:

1. Explain that uncontrolled stress is linked with increased exacerbations of rheumatoid arthritis.
2. Explain that uncontrolled stress can interfere with the treatment of rheumatoid arthritis.
3. Explain that effective stress management may reduce the number of relapses, as well as help improve the patient's health and well-being.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use, all of which can increase the risk of morbidity and mortality from rheumatoid arthritis.
5. Explain that stress may cause inappropriate eating that will exacerbate the symptoms of rheumatoid arthritis.
6. Discuss various stress management strategies that 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 healthy diet
g. Exercising regularly as tolerated
h. Taking vacations
i. Practicing meditation, self-hypnosis, and positive imagery
j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
k. Participating in spiritual or cultural activities

7. Provide referrals as appropriate.

RA-TE TESTS

OUTCOME: The patient/family/caregiver will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered and method of collection.
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 and instructions for the test.
5. Explain the meaning of the test results, as appropriate.

S

SZ - Seizure Disorder

SZ-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications of the patient's seizure disorder.

STANDARDS:

1. Explain some of the complications that may occur during a seizure, e.g., 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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in the medical plan.
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 healthcare 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 follow-up in the treatment of seizure disorder.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

SZ-L LITERATURE

OUTCOME: The patient/family will receive literature about seizure disorders.

STANDARDS:

1. Provide the patient/family with literature on seizure disorders.
2. Discuss the content of the literature.

SZ-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the impact of a seizure disorder on the patient/family's lifestyle and will make a plan for needed adaptations.

STANDARDS:

1. A healthy lifestyle should be encouraged. Encourage adequate sleep, avoid excessive fatigue, discourage use of alcohol and street drugs as these may precipitate seizures, and encourage the patient to learn to control stress, e.g., relaxation techniques. **Refer to "CPM-SM Stress Management" on page 253.**
2. Emphasize a common sense attitude toward the patient's illness. Emphasis should be placed on independence and preventing invalidism.
3. 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.
4. Instruct that pregnancy or hormone replacement therapy may lower a person's seizure threshold.
5. Inform the family to keep track of duration, frequency, and quality of seizure. Bring this log to the healthcare provider on follow-up.
6. Refer to community resources and support groups, as appropriate.

SZ-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
   a. Explain the importance of having anticonvulsant blood levels checked at regular intervals even if seizures are under control as applicable.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
   a. Of note there is an interaction between most seizure medications and birth control pills that may make the contraceptive less reliable.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

SZ-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of seizure disorder.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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, for example:
   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 the patient's 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.

3. Explain to the patient the signs and symptoms of seizure (prodrome) and to take appropriate actions, e.g., get to safe environment, move away from hazardous environment.
4. Encourage the patient to wear a medical alert bracelet.

SZ-SM STRESS MANAGEMENT

OUTCOME: 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 healthy diet
   g. Exercising regularly
   h. Taking vacations
   i. Practicing meditation, self-hypnosis, and positive imagery
   j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   k. Participating in 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 and method of collection.
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 and instructions for the test.
5. Explain the meaning of the test results, as appropriate.

SZ-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options that may be used to treat the specific condition or injury.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options.
2. Discuss the treatment plan, including lifestyle adaptation, pharmacologic, and psychosocial aspects of the treatment plan.
3. Discuss the importance of fully participating in the treatment plan, including scheduled follow-up.

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°F 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, e.g., 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 in the treatment of SARS.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

SARS-HM HOME MANAGEMENT

OUTCOME - The patient/family will understand the necessity of home management of the disease as appropriate and will 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, e.g., prevention of the spread of the SARS virus. **Refer to "SARS-LA Lifestyle Adaptations" on page 783**.
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 LITERATURE

OUTCOME: The patient/family will receive literature about acute respiratory syndrome.

STANDARDS:

1. Provide patient/family with literature on acute respiratory syndrome.
2. Discuss the content of the literature.

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 purpose, proper use, and expected outcomes of prescribed drug therapy.

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. Describe the name, strength, purpose, dosing directions, and storage of the medication.
3. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
4. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
5. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

SARS-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of SARS.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

SARS-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.

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.
4. Discuss that careful hand washing can help to prevent the spread of SARS.

5. Discuss that avoiding crowded places can decrease chances of getting SARS.
6. Discuss the importance of covering one's mouth and nose when coughing or sneezing and proper disposal of tissues.

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 and method of collection.
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 and instructions for the test, e.g., 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.

STI - Sexually Transmitted Infections

STI-C COMPLICATIONS

OUTCOME: The patient/family/partner will understand the common and important complications of sexually transmitted infections.

STANDARDS:

1. Explain that the most common complication of untreated or progressed STI is pelvic inflammatory disease, infertility, and/or sterility.
2. Explain that some STIs if left untreated can progress to disability, disfigurement, and/or death.
3. Discuss that having one sexually transmitted infection greatly increases a person's risk of having a second sexually transmitted infection.
4. Explain the importance of HIV testing and hepatitis profile A,B,&C.
5. Discuss that some sexually transmitted infection can be life-long or fatal.
6. Discuss the potential for harm to a fetus from the sexually transmitted infection or its treatment.

STI-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, e.g., diet, exercise, sleep, stress management, hygiene, full participation in the medical plan.
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 healthcare provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges, may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.

6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

STI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of sexually transmitted infections.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

STI-I INFORMATION

OUTCOME: The patient/family/partner will understand risk factors, transmission, symptoms, and complications of causative agent(s).

STANDARDS

1. Discuss the specific STI.
2. Explain the importance of partner(s) notification in the treatment and prevention of the spread of infection.
3. Explain how STIs are transmitted, e.g., semen, vaginal fluids, blood, mother to infant during pregnancy, child birth, breastfeeding, skin-to-skin contact.
4. Explain how STIs cannot be transmitted, e.g., casual contact, toilet seats, eating utensils, coughing.
5. Explain that there are no vaccines against STIs and that there is no immunity to STIs. List curable and incurable STIs. Stress the importance of early treatment.
6. Explain that infection is dependent upon behavior, not on race, age, or social status.
7. Describe how the body is affected.
8. List the symptoms of infection and how long it may take for symptoms to appear.
9. List the complications that may result if infection is not treated.
10. Review the actions to take when exposed to an STI.

STI-L LITERATURE

OUTCOME: The patient/family/partner will receive literature about sexually transmitted infections.

STANDARDS:

1. Provide the patient/family/partner with literature on sexually transmitted infections.
2. Discuss the content of the literature.

STI-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
   a. Explain that medications may cure bacterial STIs but typically provide only symptomatic relief for viral STIs.
   b. Explain that in most cases, the patient's partner(s) will need to be treated.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

STI-P PREVENTION

OUTCOME: The patient/family/partner will plan behavior patterns that will prevent STI infections.

STANDARDS:

1. List the behaviors that eliminate or decrease risk of infection, e.g., use of latex condoms, use of spermicide with condom, monogamy, abstinence, not injecting drugs. Non-latex condoms, while not as effective as latex, are recommended when latex sensitivity is an issue.

2. Describe the behavior changes that prevent transmission of STIs.
3. Discuss the proper application of a condom.
4. Describe the type of lubricant to use with condom, e.g., water-based gels, such as K-Y, Astroglide, Foreplay.
5. Describe how alcohol/substance use and/or abuse can affect the ability to use preventive measures.

STI-SM STRESS MANAGEMENT

OUTCOME: 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 healthy diet
    g. Exercising regularly
    h. Taking vacations
    i. Practicing meditation or prayer, self-hypnosis, and positive imagery
    j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    k. Participating in spiritual or cultural activities
4. Provide referrals as appropriate.

STI-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed including indications and its impact on further care.

STANDARDS:

1. Explain the test ordered, method of collection, and any special preparatory information, such as first morning void versus not voiding prior to test.
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment.
3. Explain the meaning of test results.

STI-TX TREATMENT

OUTCOME: The patient/partner/family will understand the treatment plan and complete course of treatment for improved cure rate.

STANDARDS:

1. Emphasize the importance of early detection and treatment.
2. Stress the importance of treatment of the partner to prevent re-infection and spread of the infection.
3. Discuss the patient's specific treatment plan.
4. Discuss the importance of routine follow-up and testing as appropriate.

SHI - Shingles

SHI-C COMPLICATIONS

OUTCOME: The patient or family will understand common complications of shingles.

STANDARDS:

1. Explain that when the nerves to the eyes or face are affected, they may be at increased risk for developing post-herpetic neuralgia (or PHN).
2. Discuss that shingles injures the peripheral nerves, causing pain, which may continue long after the rash has healed.
3. Explain that PHN causes the skin to become unusually sensitive to clothing, to a light touch, even to temperature.
4. Explain that if the virus invades an ophthalmic nerve it can cause painful eye inflammations that can impair the vision.
5. Explain that if shingles appear on the face and affects the auditory nerves, it can lead to complications in hearing.
6. Explain that infections of facial nerves can lead to temporary paralysis.
7. Explain that shingles sometimes develops a secondary infection that may result in scarring.

SHI-DP DISEASE PROCESS

OUTCOME: The patient/family will understand shingles and recognize its symptoms.

STANDARDS:

1. Explain that shingles (or herpes zoster) is a reactivation of a childhood chickenpox infection. However, instead of covering large parts of the body, the skin rash usually appears on a small area of skin, in rows like shingles on a roof.
2. Discuss the symptoms of shingles:
   a. Burning, tingling, or numbness of the skin.
   b. Flu like symptoms such as fever, chills, upset stomach or headache
   c. Fluid-filled blisters
   d. Skin that is sensitive to touch
   e. Mild itching to extreme and intense pain

3. Explain that a typical shingles rash follows the path of certain nerves on one side of the body, generally on the trunk, buttocks, neck, face, or scalp, and usually stops at midline.
4. Discuss the cause of reactivation is usually unknown, but seems to be linked to aging, stress, trauma or an impaired immune system.
5. Explain that contact with Shingle lesions can cause Chicken Pox in a non-immune person.

SHI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of shingles.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Explain signs or symptoms that would prompt immediate follow-up, e.g., redness, purulent discharge, fever, increased swelling, or pain.
5. Discuss the availability of community resources and support services and refer as appropriate.

SHI-L LITERATURE

OUTCOME: The parent(s) and family will receive literature about shingles.

STANDARDS:

1. Provide the parent(s) and family literature on shingles
2. Discuss the content of the literature.

SHI-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.

2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

SHI-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

SHI-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.

SHI-PM PAIN MANAGEMENT

OUTCOME: The patient will understand actions that may be taken to control pain from shingles.

STANDARDS

1. Explain that after the rash goes away, some people may be left with long lasting pain called post-herpetic neuralgia (PHN). Usually PHN pain will get better with time.
2. Explain that PHN pain is the longest lasting and worst part of shingles and needs to be discussed with the medical provider. There are a number of medications that can be prescribed to help relieve the pain. In addition, alternative approaches such as acupuncture, biofeedback, and hypnotherapy can be beneficial.
3. Discuss that prolonged pain can cause depression, anxiety, sleeplessness, and weight loss, and interfere with activities of daily living. Encourage the patient to discuss any of these problems with a provider. Explain that there are medicines that may help.
4. Explain the need to do things that take mind off pain, e.g., watch TV, read, talk with friends, or work on a hobby, share feelings about pain with family and friends, ask for help.

SHI-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in the treatment shingles.

STANDARDS:

1. Discuss that uncontrolled stress may increase alcohol and other drug use and interfere with treatment.
2. Emphasize the importance of seeking professional help as needed to reduce stress.
3. Discuss the various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
   a. Becoming aware of your own reactions to stress
   b. Recognizing and accepting your limits
   c. Talking with people you trust about your worries or problems
   d. Setting realistic and meaningful goals
   e. Getting enough sleep
   f. Making healthy food choices

g. Regular physical activity

h. Taking vacations

i. Practicing meditation, self-hypnosis, and positive imagery

j. Practicing relaxation methods such as deep breathing or progressive muscular relaxation

k. Participating in spiritual or cultural activities

4. Provide referrals as appropriate

SHI-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatment for shingles.

STANDARDS:

1. Discuss that in most cases of shingles resolve on their own without specific treatment.

2 Explain that there are many medications that can be prescribed to treat shingles when symptoms are severe. These include medicines that:

a. Fight the virus – antiviral drugs

b. Lessen pain and shorten the time you're sick – steroids

c. Reduce pain – analgesics

3. Explain that when started within 72 hours of getting the rash, these medicines help shorten the length of the infection and lower the risk of other problems.

4. Explain that cool wet compresses can be used to reduce pain. Soothing baths and lotions, such as colloidal oatmeal bath or lotions and calamine lotion, may help to relieve itching and discomfort.

5. Discuss other things that may help to feel better including adequate rest, eating healthy meals and avoiding stress as much as possible. Try to relax. Stress can make the pain worse.

SWI - Skin and Wound Infections

SWI-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications associated with skin and wound infections.

STANDARDS:

1. Review with the patient/family the symptoms of a generalized infection, e.g., 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 (e.g., cellulitis) or generalized infection, e.g., 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 - Peripheral Vascular Disease" on page 681.**
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 in the treatment of skin and wound infections.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Explain signs or symptoms that would prompt immediate follow-up, e.g., redness, purulent discharge, fever, increased swelling or pain.
5. Discuss the availability of community resources and support services and refer as appropriate.

SWI-L LITERATURE

OUTCOME: The patient/family will receive literature about skin and wound infections.

STANDARDS:

1. Provide patient/family with literature on skin and wound infections.

2. Discuss the content of the literature.

SWI-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

SWI-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.

SWI-N NUTRITION

OUTCOME: The patient/family will understand the role of adequate nutrition for the healing of skin and wound infections.

STANDARDS:

1. Explain the importance of adequate nutrition and hydration in the repair of tissue.
2. Refer to a registered dietician as appropriate.

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 (e.g., 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 "HPDP-HY Hygiene" on page 481.**
3. Review importance of maintaining good general health and controlling chronic medical conditions, especially glycemic control in diabetes. **Refer to "DM-FTC Foot Care And Examinations" on page 321.**

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 - Pain Management" on page 657.**
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-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 collection method.
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 and instructions 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, e.g., 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, e.g., rheumatic fever or glomerulonephritis.
2. List the symptoms that should be reported immediately, e.g., drooling, difficulty swallowing, blood in the urine, joint pains, abnormal movements, and fever lasting longer than 48 hours after starting antibiotic.
3. Stress the 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, e.g., 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 Complications" on page 801.**

ST-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of strep throat.

STANDARDS:

1. Discuss the importance of follow-up care.

2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

ST-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive literature about strep throat.

STANDARDS:

1. Provide patient/family with literature on strep throat.
2. Discuss the content of the literature.

ST-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
   a. 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.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

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, e.g., 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, e.g., 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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in the medical plan.
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 healthcare 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 and is also called crib death. 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 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.

3. 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.
4. 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 overheating baby while sleeping with too much clothing and/or bedding. Avoid alcohol use anytime, especially in the first trimester of pregnancy.

SIDS-L LITERATURE

OUTCOME: The parent(s) and family will receive literature about Sudden Infant Death Syndrome.

STANDARDS:

1. Provide the parent(s) and family with literature on SIDS.
2. Discuss the content of the literature.

SIDS-P PREVENTION

OUTCOME: The parents and/or family will understand the factors associated with an increased risk of SIDS and will identify things that can be done to reduce the risk of a SIDS death.

STANDARDS

1. Explain that placing your baby on the baby's 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. 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. Emphasize tummy time is for babies who are awake and being watched and is important for infant development and will make neck and shoulder muscles stronger. Remember, "Back to Sleep, Tummy to Play."
3. Explain that side sleeping is not as safe as back sleeping and is not advised. Babies who sleep on their sides can roll onto their stomach and have an increased risk of SIDS.
4. 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. This can be prevented by alternating the head of the bed to the foot of the bed on alternate nights.

5. Encourage the client to be receptive to home visits by public health nurses because 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. Emphasize the safest place for a baby to sleep is in a crib on and firm mattress. 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. Discuss potential hazards of overheating. Consider dressing your baby in sleep clothing such as a sleep sack or a wearable blanket so no other covering is needed (use no more than 2 layers of clothing). If a sheet or thin blanket is used, tuck it in reaching only as far as the baby's chest. The room temperature should be comfortable.
3. 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.
4. Explain that it has been shown that the risk of SIDS is lower when a pacifier is used during sleep. Consider offering a pacifier at nap time and bedtime. Do not force use and do not reinsert a pacifier after the infant falls asleep. For breastfed babies, the pacifier should be delayed until 1 month of age to ensure breastfeeding is firmly established. Emphasize the use of hot, soapy water to clean the pacifier and to change to a new one frequently.

SIDS-SHS SECOND-HAND SMOKE

OUTCOME: The patient/family will understand the adverse health consequences associated with exposure to second-hand tobacco smoke.

STANDARDS:

1. Define "passive smoking" and ways in which exposure occurs, e.g., smoldering tobacco, exhaled smoke, residue in carpet.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, CO, carcinogens.

3. Explain the increased risk of illness in children and adults when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia, lung cancer.
4. Emphasize that the infants who are exposed to smoke in the home are three times more likely to die of SIDS than infants who live in a non-smoker's home.
5. Explain that cigarette smoke trapped in carpets, upholstery, and clothing still increases the risk of illness.
6. Discuss that having household members smoke outside and removing smoke contaminated clothing may decrease exposure to second hand smoke.
7. Encourage smoking cessation or at least never smoking in the home or car. **Refer to "TO-QT Quit" on page 832.**

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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in the medical plan.
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 healthcare 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 in the treatment of suicidal behavior.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

SB-L LITERATURE

OUTCOME: The patient/family will receive literature about suicidal behavior.

STANDARDS:

1. Provide the patient/family with literature on suicidal behavior.
2. Discuss the content of the literature.

SB-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Explain the need for smaller quantities of medications dispensed at one time and close monitoring of medication refill history, as applicable.
3. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
4. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
5. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

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

OUTCOME: 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 self destructive behavior may result from any stress the person feels is overwhelming.
3. Explain that uncontrolled stress can interfere with the treatment of suicidal behaviors. Discuss early symptoms of anxiety to prevent it from escalating; e.g. sweaty palms, racing heart, difficulty concentrating.
4. Explain that effective stress management may reduce the severity of symptoms the patient experiences, as well as help improve the health and well-being of the patient.
5. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all of which can increase the severity of the depression and increase risk of suicidal behaviors.
6. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. Becoming aware of your own reactions to stress
    b. Recognizing and accepting your limits
    c. Talking with people you trust about your worries or problems
    d. Setting realistic goals
    e. Getting enough sleep
    f. Maintaining a healthy diet (Refer to dietitian as appropriate.)
    g. Avoiding caffeine and alcoholic beverages
    h. Exercising regularly
    i. Taking vacations

j. Participating in enjoyable social activities

k. Practicing meditation, self-hypnosis, and positive imagery

l. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation

m. Participating in spiritual or cultural activities

7. Provide referrals as appropriate. Discuss how to access available community resources and support groups.

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.
4. Discuss negotiation of a no-suicide or no-harm contract.

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 "HPDP-N Nutrition" on page 483.**
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 - Alcohol and Other Drugs" on page 42.**

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 - Domestic Violence" on page 346.**
6. Explain other ways the patient can use to 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; be 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 common complications associated with excessive sun exposure includes sun burns, skin cancers, and premature aging of the skin.
2. Explain that sunburns before the age of 18 are more likely to cause skin cancers later on in life.
3. Discuss the four 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
4. Explain that complications of sun burn may include dehydration, pain, redness, swelling, and some blistering. Secondary infections from sunburns may result from sunburns that blister and peel. Because sun burn often affects a large area, it can also cause headache, fever, and fatigue.

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 UV, or ultraviolet, rays are the sun's invisible burning rays. 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 that may contribute to cancer.
2. Explain that UVA rays are a deeper penetrating radiation that contributes to premature aging and wrinkle formation. It causes the leathery, sagging, brown-spotted skin. UVA can also penetrate window glass, including car windows. Tanning beds are a source of high doses of UVA.
3. Explain that UVB rays cause sunburn and have been linked to the development of skin cancer. Window glass filters out UVB rays.

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-L LITERATURE

OUTCOME: The parent(s) and family will receive literature appropriate to the type and degree of the sunburn.

STANDARDS:

1. Provide literature on first and second-degree burns.
2. Discuss the content of the literature.

SUN-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle adaptations necessary to prevent complications of sunburn.

STANDARDS:

1. Explain that regardless of age and skin pigmentation, all people are at risk for sun damage to their skin and should wear sunscreen. **Refer to "SUN-P Prevention" on page 815.**
2. Explain that the UV content of sunlight varies depending on various factors. Emphasize the need to adapt outdoor activities and/or take appropriate protective measures with consideration for these factors. **Refer to "SUN-P Prevention" on page 815.**
    a. Time of day (UV content greatest between 11 AM and 4 PM)
    b. Season (UV content greatest May - August)
    c. Altitude (UV content greatest at higher altitudes)
    d. Exposure time (longer exposure, higher risk of sunburn)
    e. Surfaces (snow, sand, and water are highly reflective surfaces)

3. Discuss the importance of setting up a schedule to routinely check the skin for changes. Check your birthday suit on your birthday. If you notice anything changing, growing, or bleeding on your skin, see your doctor.
4. Explain the importance of eliminating the use of alcohol and other drugs when participating in outdoor activities because they can impair judgment and interfere with sound decision-making.

SUN-P PREVENTION

OUTCOME: The patient/family will understand the factors associated with an increased risk of sunburns, how to lower the risk of sunburn, and how to prevent complications.

STANDARDS

1. Explain that consistent use of sunscreen each and every day, year around is the key to preventing sunburn, sun damage, and skin cancer. Emphasize the importance of protecting infants, children, and youth. Apply appropriately:
   a. Apply liberally before going outside (at least 30 minutes prior) to cover all exposed areas of the body including neck, ears, lips, and exposed scalp.
   b. Reapply (even if water resistant) every 90 minutes, including on cloudy days and after swimming or sweating.
2. Discuss what to look for when purchasing sunscreen to ensure protection:
   a. Ensure that the product is a broad spectrum sunscreen offering both UVA and UVB protection.
   b. Ensure that the minimum level of SPF (Sun Protection Factor) rating purchased is SPF 15. The SPF rating indicates how much longer a person wearing sunscreen can stay in the sun before beginning to burn compared to uncovered skin. For example, SPF 15 means it will take 15 times longer to burn when wearing this sunscreen.
3. 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.
4. Explain that if a tan is desired, consider use of one of the many "bronzers" available at cosmetic counters. Emphasize that sunscreen must be used over the "bronzer" because bronzers usually do not contain sunscreens.
5. Discuss additional things that offer sun protection for work or play:
   a. Wear a broad-brimmed hat
   b. Wear light-colored clothing that covers exposed skin
   c. Wear wraparound UVA- and UVB-rated sunglasses
   d. Limit outdoor activities to the early morning or late afternoon when possible

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. Discuss tips for treating sunburn:
   a. Take a cool bath or shower or apply cool compresses.
   b. Apply an aloe vera lotion several times a day.
   c. Leave blisters intact to speed healing and to avoid infection. If they burst, apply an antibacterial ointment on the open areas and cover with a sterile gauze bandage.
   d. Take a mild over-the-counter analgesic for discomfort.
   e. Drink plenty of water or other non-caffeinated beverages.
2. Explain that severe sunburn may require and benefit from medical attention. Seek medical attention if the following conditions accompany sunburn:
   a. Fever over 101^{o}F
   b. Fluid-filled blisters over half of the affected body part
   c. Dizziness
   d. Visual difficulties
   e. Severe pain
   f. Infants less than 1 year of age with fever, blisters, pain
3. **Refer to "BURN - Burns" on page 145.**

SUP - Supplements, Dietary

SUP-C COMPLICATIONS

OUTCOME: The patient and/or family will understand that excessive intake of vitamins and/or minerals through supplements or functional foods can cause adverse effects up to and including death.

STANDARDS:

1. Explain that some vitamin and/or mineral supplements may interfere with medications. Refer the patient to their physician or pharmacist for more specific information. Stress the importance of consulting a physician, registered dietician, and pharmacist before starting any new supplement.
2. Explain that it is important to inform your doctor about any medications, vitamins, minerals, and other supplements you are taking, especially before surgery to avoid potentially dangerous supplement/drug interactions; e.g. changes in heart rate, blood pressure, and increased bleeding.
3. Explain that megadoses of vitamins, minerals, or other supplements may have toxic effects.
4. Discuss common and important signs/symptoms of toxicity as it relates to the patient's supplement regimen.
5. Refer to registered dietician, physician, and pharmacist for specific recommendation.

SUP-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of follow-up for supplements issues.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

SUP-I SUPPLEMENT INFORMATION

OUTCOME: The patient/family will understand the indication for supplements including the specific disease process most influenced with the prescribed supplement. Side effects and or negative outcomes will be reviewed in regard to over supplementation.

STANDARDS:

1. Explain that a dietary supplement is a product that is intended to supplement the diet and may contain not only vitamins and minerals but also less familiar substances such as herbals, botanicals, amino acids, and enzymes.
2. Explain that dietary supplements are not intended to treat, diagnose, mitigate, prevent, or cure disease.
3. Explain the indication for supplementation. As appropriate, discuss supplements which may be appropriate for this patient's disease state, condition, or medication regimen and any supplements that may be contraindicated in this disease state, condition, or medication regimen.
4. Explain the importance of vitamins, minerals, and other supplements in the normal functioning of the body.
5. Vitamins are organic compounds, 13 vitamins have been discovered, 4 of these vitamins are fat soluble and 9 are water soluble.
6. Minerals are inorganic compounds because they do not contain carbon structures. There are 22 essential minerals that are needed in the diet.
7. Macrominerals that are needed in large amounts include the following: calcium, phosphorus, magnesium, potassium, sodium, chloride, and sulfur.
8. Trace minerals include but are not limited to the following: iron, copper, selenium, fluoride, iodine, chromium, zinc, manganese, molybdenum, and cobalt.
9. Food fortification and functional foods play a very important role in determining the type and supplementation that a patient will receive.

SUP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of the patient's condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.

c. Identification of a specific nutrition intervention therapy plan.

d. Evaluation of the patient's nutritional care outcomes.

e. Reassessment as needed.

2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

SUP-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.

SUP-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand the importance of working with members of the healthcare team to determine how best to achieve optimal health and make informed decisions about dietary supplements to improve safety and prevent adverse effects.

STANDARDS:

1. Emphasize the importance of checking with healthcare providers before taking a supplement, especially when combining them with or substituting them for other foods and medicines.
2. Explain that it is very important to seek the advice of a physician if you are:
   a. Chronically ill
   b. Taking prescription or over the counter (OTC) drugs
   c. Pregnant or potentially pregnant
   d. Breastfeeding
   e. Under the age 18 or over the age 64
   f. Unsure about taking a supplement

g. Unsure if you need a supplement or not

3. Discuss how to protect yourself before purchasing or taking any dietary supplements.
   a. Educate yourself about the ingredients in dietary supplements. Know what you are taking and why you are taking it.
   b. Stay informed, listen to the news and check with the FDA Website (www.fda.gov) for information about recalls or warnings about supplements.
   c. The term natural doesn't always mean safe. Do not assume that this term ensures wholesomeness or safety.
   d. Always read the label and look for warnings, cautions, interactions, and side effects.
   e. Do not believe the hype. If something sounds too good to be true, it probably is.
   f. Do not substitute a dietary supplement for a prescription medicine, prescribed therapy, or the foods important to a healthful diet.
   g. More may not be better. Some products can be harmful when consumed in high amounts, for a long time, or in combination with certain other substances.
   h. When purchasing dietary supplements on the Web, use sites of respected organizations.
4. Explain that unlike drugs, dietary supplements are not approved by the FDA for safety and effectiveness. Once on the market, the FDA has the authority to take action against any dietary supplement that presents a significant or unreasonable risk of illness or injury.
5. Explain that one way to protect yourself when purchasing dietary supplements is to look for the USP-verified mark on the container. This mark indicates that USP (US Pharmacopeia) has rigorously tested and verified the supplement to assure integrity, purity, dissolution, and safe manufacturing. The USP does not test for efficacy.
6. Emphasize the importance of contacting your doctor if you think you've had an adverse reaction to a dietary supplement.

SUP-SCH SCHEDULE

OUTCOME: The patient/family will understand the importance of following the prescribed timing of supplements in regard to other foods and medications.

STANDARDS:

1. Explain that the use of all vitamin/mineral or other type of supplements should be used only under the advice of a registered dietician and a physician.

2. Explain that some supplements may require specific timing when taking other medications and/or supplements, e.g., calcium is better absorbed with a meal but should not usually be taken at the same time as iron supplements.
3. Review the schedule with patient and/or family.

SPE - Surgical Procedures and Endoscopy

SPE-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family/caregiver will understand the process of developing an advance directive and its role in maintaining a sense of control in the patient's medical care and decisions.

STANDARDS:

1. Explain that patients may lose the ability to make their own decisions and an advance directive will be able to express the patient's desires prior to the loss of decision-making abilities.
2. Review the option of Advanced Directives/Living Will with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
3. Refer to appropriate services to assist the patient in making a living will, e.g., Social Services, Clergy, Lawyer.
4. **Refer to "ADV - Advance Directives" on page 40.**

SPE-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and important complications of the proposed procedure.

STANDARDS:

1. Discuss the common and important complications of the proposed procedure.
2. Discuss alternatives to the proposed procedure.

SPE-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges, may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

SPE-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss the types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate the proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss the signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss the proper disposal of associated medical supplies.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

SPE-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of the surgical procedures and endoscopy.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.

4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

SPE-IS INCENTIVE SPIROMETRY

OUTCOME: The patient will understand the reason for use of the incentive spirometer and demonstrate appropriate use.

STANDARDS:

1. Explain that regular and appropriate use of the incentive spirometer according to instructions reduces the risk of respiratory complications including pneumonia.
2. Explain that the optimal body position for incentive spirometry is semi-Fowler's position that allows for free movement of the diaphragm.
3. Instruct the patient to exhale normally and evenly inhale maximally through the spirometer mouthpiece.
4. Encourage the patient to hold the maximal inspiration for a minimum of three seconds to allow for redistribution of gas and opening of atelectatic areas.
5. Instruct the patient to exhale slowly and breathe normally between maneuvers.
6. Instruct the patient to repeat this maneuver as frequently as prescribed.

SPE-L LITERATURE

OUTCOME: The patient/family will receive literature about the surgical procedure or endoscopy.

STANDARDS:

1. Provide the patient/family with literature on the surgical procedure or endoscopy.
2. Discuss the content of the literature.

SPE-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.

a. Explain the need for a designated driver due to medications with sedating side effects.

3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

SPE-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain the pain scale and how it is used to assess the degree of pain individuals are experiencing. Discuss its use in developing a plan to manage pain.
2. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to "PM - Pain Management" on page 657.**
3. Explain that short term use of narcotics may be helpful in pain management as appropriate.
4. Explain that other medications may be helpful to control the symptoms of pain.
5. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
6. Discuss non-pharmacologic measures that may be helpful with pain control.

SPE-PO POSTOPERATIVE

OUTCOME: Patient/family will be knowledgeable about the post-operative course and home management as appropriate.

STANDARDS:

1. Review the post-op routine.
2. Discuss the symptoms of complications.
3. Review the plan for pain management.
4. Discuss the home management plan in detail, including activities, incision care, diet, medications, signs or symptoms which should prompt re-evaluation, follow-up, and any referrals.
5. Emphasize the importance of full participation with the plan for follow-up care.

SPE-PR PREOPERATIVE

OUTCOME: Patient/family will be prepared for surgery or other procedure.

STANDARDS:

1. Explain the pre-operative preparation, e.g., bathing, bowel preps, diet instructions.
2. Explain the proposed surgery or other procedure, including anatomy and physiology, alteration in function, risks, benefits, etc.
3. Discuss the common or potentially serious complications.
4. Explain the usual pre-operative routine for the patient's procedure.
5. Explain that before the procedure begins, the patient may be asked to participate in marking the surgical site.
6. Discuss what to expect after the procedure.
7. Discuss pain management.

SPE-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure, including indications, complications and alternatives, as well as possible results of non-treatment.

STANDARDS:

1. Discuss the indications, risks, benefits, any significant alternatives, likelihood of success, and common and important complications of the proposed procedure. Discuss the possible results of non-treatment and any potential problems related to recuperation.
2. Explain the process and what to expect after the procedure.
3. Explain the necessary preparation, e.g., bowel preps, diet instructions, bathing.

SPE-TCB TURN, COUGH, DEEP BREATH

OUTCOME: The patient/family will understand why it is important to turn, cough and deep breath and the patient will be able to demonstrate appropriate deep breathing and coughing.

STANDARDS:

1. Explain that it is important to frequently (every 1 to 2 hours) turn, cough and breath deeply to prevent complications such as pneumonia after a surgical procedure. Explain that turning prevents stasis of secretions and breathing deeply and coughing helps to mobilize and clear secretions and keep small airways open.

2. Describe appropriate deep breathing and coughing (take a large breath and hold it for 3–5 seconds, exhale and cough shortly 2 to 3 times).
3. Demonstrate appropriate splinting techniques (e.g., using a pillow held tightly to the abdomen over the surgical site).
4. Have the patient return a demonstration of appropriate deep breathing, coughing, and splinting.

SPE-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered and method of collection.
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 (e.g. fasting) for the test and instructions for collection (e.g. clean catch urine).
5. Explain the meaning of the test results, as appropriate.

SPE-WC WOUND CARE

OUTCOME: The patient/family will understand the necessity and procedure for proper wound care. As appropriate they will demonstrate the necessary wound care techniques.

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Explain the correct procedure for caring for this patient's wound, dressing technique, and suture care as appropriate.
3. Explain signs or symptoms that should prompt immediate follow-up, e.g., 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 and the proper disposal of contaminated items.
5. Emphasize the importance of follow-up.

T

TO - Tobacco Use

TO-C COMPLICATIONS

OUTCOME: The patient/family will understand the slow progression of disease and disability resulting from tobacco use and its effect on family members.

STANDARDS:

1. Discuss the common problems associated with tobacco use and the long term effects of continued use of tobacco, e.g., COPD, cardiovascular disease, dental disease, impotence, slower healing rate, placental insufficiency, low birth weight, and fetal demise, numerous kinds of cancers including lung cancer. **Refer to "PN-TO Tobacco" on page 731.**
2. Discuss that tobacco use causes damage to the entire body and results in numerous chronic diseases, many of which are irreversible and debilitating.
3. Review the effects of tobacco use on all family members. e.g., financial burden, greater risk of fire, and early death.
4. Review the effects of second hand smoke and associated risks e.g., increased risk of SIDS, exacerbation of asthma, increased risk of infection, early death. **Refer to "TO-SHS Second-Hand Smoke" on page 833.**
5. Discuss, as appropriate, that tobacco mixed with any other substance may be more dangerous and may cause more complications. e.g., ash or other chemicals.

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. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Explain that differences exist between spiritual tobacco use and tobacco abuse and addiction.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are interactions with prescribed treatment.
3. 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. **Refer to "TO-C Complications" on page 828.**
2. Explain nicotine addiction. Discuss that nicotine is rapidly addictive and an exceedingly difficult addiction to break.
3. Explain that most patients require 5-7 attempts to stop tobacco use for life.

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. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Discuss obstacles to a personal exercise plan and solutions to those obstacles. Assist the patient in developing a personal exercise plan.
4. Encourage the patient to increase the intensity and duration of the activity as the patient becomes more fit.
5. Refer to community resources as appropriate.

TO-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of nicotine addiction.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.

5. Discuss the availability of community resources and support services and refer as appropriate.

TO-HY HYGIENE

OUTCOME: The patient/family will understand hygiene as it applies to tobacco use.

STANDARDS:

1. Discuss hygiene as part of a positive self image.
2. Review bathing, dental hygiene, and laundry/house cleaning (to reduce tobacco residue/odor).

TO-IR INFORMATION AND REFERRAL

OUTCOME: The patient/family will understand the process of referral and treatment for nicotine dependence.

STANDARDS:

1. Discuss sources for tobacco cessation treatment.
2. Refer to nicotine treatment program or other resource as available.

TO-L LITERATURE

OUTCOME: The patient/family will receive literature about tobacco use or cessation.

STANDARDS:

1. Provide the patient/family with literature on tobacco use or cessation.
2. Discuss the content of the literature.

TO-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will see tobacco abstinence as a way of life.

STANDARDS:

1. Discuss the patient's use/abuse of tobacco.
2. Discuss tips for stress relief and "healthy replacement habits."

TO-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
    a. 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.
    b. Explain that some medications may not work right away but will require a few days to a few weeks to take effect.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

TO-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed in tobacco use.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
    a. Assessment of the nutrition related condition.
    b. Identification of the patient's nutritional problem.
    c. Identification of a specific nutrition intervention therapy plan.
    d. Evaluation of the patient's nutritional care outcomes.
    e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

TO-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition and tobacco use.

STANDARDS:

1. Explain the importance of healthy eating habits and for optimal health.
2. Explain that vitamin C requirements are higher for smokers. Vitamin C sources include, citrus fruits, strawberries, cantaloupe, spinach.
3. Refer to a registered dietitian for MNT as needed.

TO-P PREVENTION

OUTCOME: The patient/family will understand tobacco use prevention.

STANDARDS:

1. Discuss risk factors for tobacco use, e.g., parents/family/friends who use tobacco, peer/social pressure, stress, environments that are conducive to use of tobacco (bars, casinos, rodeos), availability of cigarettes.
2. Discuss methods (as appropriate to this patient) to avoid ever using tobacco.

TO-QT QUIT

OUTCOME: The patient/family will understand that tobacco cessation will improve quality of life. use is a serious health threat, may be more motivated to quit, and that cessation will benefit health and how participation in a support program may prevent relapse.

STANDARDS:

1. Advise the patient to quit.
2. Discuss that readiness and personal motivation are key components to quitting.
3. Review the treatment, medication, and support options available to the patient/ family. Make referrals as appropriate. **Refer to "TO-IR Information and Referral" on page 830.**
4. Review the value of frequent follow up and support during the first months of cessation.

TO-S SAFETY

OUTCOME: The patient/family will understand safety issues as they apply tobacco use.

STANDARDS:

1. Discuss that smoking in bed or falling asleep while smoking greatly increases the risk of house fires. Emphasize to never smoke while in bed or if sleepy.
2. Discuss the risk of cigarette burns.

3. Discuss that smoking while driving is a distraction and increases the risk of motor vehicle crash.

TO-SHS SECOND-HAND SMOKE

OUTCOME: The patient/family will understand the adverse health consequences associated with exposure to second-hand tobacco smoke.

STANDARDS:

1. Define "passive smoking" and ways in which exposure occurs, e.g., smoldering tobacco, exhaled smoke, residue in carpet.
2. Discuss harmful substances in smoke e.g., nicotine, benzene, CO, carcinogens
3. Explain the increased risk of illness in children and adults when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia, lung cancer.
4. Emphasize that the infants who are exposed to smoke in the home are three times more likely to die of SIDS than infants who live in a non-smoker's home.
5. Explain that cigarette smoke trapped in carpets, upholstery, and clothing still increases the risk of illness.
6. Discuss that having household members smoke outside and removing smoke contaminated clothing may decrease exposure to second hand smoke.
7. Encourage smoking cessation or at least never smoking in the home or car. **Refer to "TO-QT Quit" on page 832.**

TO-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in tobacco abuse and its positive effect on tobacco cessation.

STANDARDS:

1. Discuss that uncontrolled stress may increase tobacco use and interfere with tobacco cessation.
1. 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.
1. 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 healthy diet
g. Exercising regularly
h. Taking vacations
i. Practicing meditation, self-hypnosis, and positive imagery
j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
k. Participating in spiritual or cultural activities

2. Provide referrals as appropriate.

TB - Tuberculosis

TB-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

TB-DOT DIRECTLY OBSERVED THERAPY

OUTCOME: The patient/family will understand the importance of fully participating with a prescribed medication regimen using the directly observed therapy (DOT) regimen for TB.

STANDARDS:

1. Provide a pill count.
2. Discuss the use, benefits, and common side effects of prescribed medications.
3. Discuss the patient's full participation / non-participation. Discuss the consequences of non-participation.
4. Discuss the procedure for DOT.

5. Discuss criteria used to determine when patients can be considered noninfectious; e.g. adequate treatment for 2-3 weeks, improved symptoms, 3 negative sputum smears.

TB-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the etiology, pathophysiology, and communicability of tuberculosis infection and tuberculosis disease.

STANDARDS:

1. Review the anatomy and physiology of the affected system, e.g., respiratory, lymphatic.
2. Review the hygiene and infection control as it relates to TB infection and TB disease. Review the factors associated with infectiousness (TB of lung, have not received adequate treatment, drug-resistant TB) and discuss how TB is spread.
3. Explain that certain people are at higher risk for exposure or infection (elderly, low income, contact to person with infectious TB) and some conditions appear to increase the risk that TB infection will progress to disease (e.g. illicit drug use, HIV, certain medical conditions).
4. Explain the patient's specific disease process and review the way TB infection and TB disease develop in the body and describe the symptoms of TB disease; e.g. night sweats, fever, weight loss.
5. Explain the most common complications of the disease process.

TB-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of tuberculosis.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

TB-L LITERATURE

OUTCOME: The patient/family will receive literature about tuberculosis.

STANDARDS:

1. Provide the patient/family with literature on tuberculosis.
2. Discuss the content of the literature.

TB-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

TB-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of TB.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.

4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

TB-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.

TB-P PREVENTION

OUTCOME: The patient/family will understand communicability and preventive measures for TB.

STANDARDS:

1. Emphasize the importance of early detection and treatment of TB.
2. Discuss the mode of transmission and methods for reducing the risk of contracting TB, e.g., hand washing, covering the mouth when coughing or sneezing, disposing of contaminated materials.
3. Explain that when treated as an outpatient, patients with active TB must wear a mask until they have completed at least two weeks of treatment.
4. Explain the purpose of the isolation room and mask for patients who have signs or symptoms of TB disease. Emphasize the importance of staying in the room and wearing the surgical mask until the diagnostic evaluation is completed.
5. Review the actions to take when exposed to TB.

TB-PPD SCREENING SKIN TEST

OUTCOME: Patient/family will understand the importance of screening and follow-up and the meaning of the result.

STANDARDS:

1. Discuss the purpose, procedure, and meaning of the screening test and results if available.

2. Emphasize the importance of screening annually or on another schedule as appropriate.
3. Explain that a person who has reacted positively in the past will always react positively in the future and repeat testing may not be appropriate, or other types of testing may be indicated.

TB-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered and method of collection or mode obtained.
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 and instructions for the test.
5. Explain the meaning of the test results, as appropriate.

TB-TX TREATMENT

OUTCOME: The patient/family will understand the treatment plan for preventive therapy for TB infection or the treatment of TB disease and the importance of full participation in the treatment regimen.

STANDARDS:

1. Explain that preventive therapy is medication that is given to people who have TB infection to prevent them from developing TB disease. Describe the usual preventive therapy regime.
2. Emphasize that some TB infected people are at very high risk of developing TB disease (e.g. elderly, low income, homeless, illicit drug users) and receive high priority for preventive therapy.
3. Explain the recommended treatment regime for patients with TB disease and why the disease must be treated for at least six months and sometimes longer. If appropriate, explain why directly observed therapy is important.
4. Discuss the specific treatment plan. Describe how patients will be monitored for adherence to the treatment plan and evaluated for their response to treatment. Describe the role of the public health worker in TB treatment.

U

UC - Ulcerative Colitis

UC-C COMPLICATIONS

OUTCOME: The patient/family will understand the signs of complications of ulcerative colitis and will plan to return for medical care if they occur.

STANDARDS:

1. Explain that intestinal complications of ulcerative colitis include toxic megacolon and colon cancer. People who have ulcerative colitis for a long time are at an increased risk for developing colon cancer.
2. Explain that the disease can also cause non-intestinal problems in other parts of the body. Some people experience arthritis, eye problems, liver problems, osteoporosis, skin rashes, and anemia.
3. Explain that some other possible complications of ulcerative colitis are colon perforation, hemorrhage, abdominal distention, abscess formation, stricture, anal fistula, malnutrition, electrolyte imbalance, skin ulceration, ankylosing spondylitis.
4. Explain that complications may be delayed, minimized or prevented with prompt treatment of exacerbation.
5. Discuss the symptoms of exacerbation that trigger the need to seek medical attention, e.g., unusual abdominal pain, blood in stools, fever, weight loss, change in frequency of stools, joint pain.

UC-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving physical and behavioral health.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, and providers in the case management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the case management plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated case management and to maintain patient privacy and confidentiality. **Refer to "AF-CON Confidentiality" on page 33**.

UC-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges, may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

UC-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of the patient's specific bowel disease.

STANDARDS:

1. Explain that ulcerative colitis is a chronic disease that affects the colon or large intestine. The innermost lining, called the mucosa, becomes inflamed and develops tiny open sores that bleed and produce pus and mucus.
2. Explain that the exact cause of ulcerative colitis is unknown, but may be related to infection, stress, allergy, autoimmunity, and familial predisposition.
3. Explain that this disease usually develops during young-adulthood to middle life.
4. Explain that the severity of symptoms usually depends on where the inflammation and ulcerations are in the colon. Common symptoms include diarrhea, bloody diarrhea, and abdominal cramping which may be severe. May also experience fatigue, weight loss, anorexia, nausea, vomiting, loss of body fluids and nutrients, and abdominal pain.

5. Explain that ulcerative colitis is characterized by remissions and exacerbations.
6. Explain that careful medical management may eliminate/postpone the need for surgical intervention.

UC-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of ulcerative colitis.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss the symptoms of exacerbation that trigger the need to seek medical attention, e.g., unusual abdominal pain, blood in stools, fever, weight loss, change in frequency of stools, joint pain.
5. Discuss the availability of community resources and support services and refer as appropriate.

UC-L LITERATURE

OUTCOME: The patient/family will receive literature about ulcerative colitis.

STANDARDS:

1. Provide the patient/family with literature on ulcerative colitis.
2. Discuss the content of the literature.

UC-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.

3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

UC-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

UC-N NUTRITION

OUTCOME: The patient/family will understand how dietary modification may assist in the control of bowel function and will develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.
2. Advise the patient to avoid dairy products if the patient is lactose intolerant.
3. Encourage the patient/family to maintain a well-balanced, low-residue, high-protein diet.

4. Assist the patient/family to identify foods which cause irritation and encourage them to eliminate or minimize these in the diet. Explain that bland, soft foods may cause less discomfort than spicy or high fiber foods when the disease is active.
5. Explain the need to consume ample fluids because chronic diarrhea can lead to dehydration. Advise the patient to avoid cold or carbonated foods or drinks that increase intestinal motility.
6. Assist the patient/family in developing appropriate meal plans. Encourage having frequent, small meals and chewing food thoroughly.
7. Emphasize that proper nutrition is especially important because nutrients can be lost through dehydration. Explain that supplementation with vitamins and minerals may be necessary.
8. Refer to dietitian as appropriate.

UC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Discuss the plan for sedatives and tranquilizers to provide, not only for rest, but to decrease peristalsis and subsequent cramping.
2. Instruct the patient in careful cleansing and protection of the perianal skin to provide comfort and prevent painful excoriation.
3. Explain that short term use of narcotics may be helpful in acute pain management.
4. Advise the patient not to use over the counter pain medications without checking with the patient's provider.

UC-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in ulcerative colitis.

STANDARDS:

1. Explain that uncontrolled stress is linked with increased exacerbations of ulcerative colitis.
2. Explain that uncontrolled stress can interfere with the treatment of ulcerative colitis.
3. Explain that effective stress management may reduce the number of relapses, as well as help improve the patient's health and well-being.

4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use, all of which can increase the risk of morbidity and mortality from ulcerative colitis.
5. Explain that stress may cause inappropriate eating which will exacerbate the symptoms of ulcerative colitis. **Refer to "UC-N Nutrition" on page 843.**
6. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
   a. Becoming aware of your own reactions to stress
   b. Recognizing and accepting your limits
   c. Talking with people you trust about your worries or problems
   d. Setting realistic goals
   e. Getting enough sleep
   f. Maintaining a healthy diet
   g. Exercising regularly
   h. Taking vacations
   i. Practicing meditation, self-hypnosis, and positive imagery
   j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   k. Participating in spiritual or cultural activities
7. Provide referrals as appropriate.

UC-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Proctosigmoidoscopy and Colonoscopy
   a. Explain that proctosigmoidoscopy and colonoscopy may be utilized to directly visualize the inside of the colon and enable biopsies to be obtained. The information from the colonoscopy may be necessary to diagnose the specific type of bowel disease.
   b. Explain that the procedure involves introducing a long, flexible, lighted tube into the anus to see the inside of the colon and rectum.
   c. Explain that the preparation for the test is usually a liquid diet, cathartics, and enemas.
2. Upper gastrointestinal barium studies

a. Explain that the upper GI barium study is an x-ray to assess the degree and extent of the disease.

b. Explain that barium liquid will be swallowed and radiographs taken.

3. Barium Enema

a. Explain that the barium enema is an x-ray to assess the extent of the disease, identify lesions, detect pseudo polyps, carcinoma, and strictures.

b. Explain that barium liquid will be introduced by enema and radiographs taken.

c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.

4. Explain that if the procedure/test involves sedation, the patient will have to bring a driver with them.

UC-TX TREATMENT

OUTCOME: The patient/family will understand the appropriate treatment for ulcerative colitis and have a plan to fully participate in the treatment regimen. The patient/family will further understand the risk/benefit ratio of the testing proposed as well as alternatives to testing and the risk of non-testing.

STANDARDS:

1. Explain the goals of treatment are to control the acute attacks, prevent recurrent attacks, and promote healing of the colon. Discuss the specific treatment plan, which may include the following:

a. Bed rest.

b. IV fluid replacement to correct dehydration.

c. Clear liquid diet, or in severe cases, parenteral hyperalimentation to rest the intestinal tract and restore nitrogen balance.

d. Treatment with medication to control inflammation and help reduce diarrhea, bleeding, and pain.

e. Colectomy.

2. Discuss the risk/benefit ratio and alternatives to treatment as well as the risk of non-treatment.

URI - Upper Respiratory Track 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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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, e.g., direct physical contact, children in school.
4. Discuss signs and symptoms of an upper respiratory infection, e.g., malaise, rhinorrhea, sneezing, scratchy throat.
5. Discuss signs and symptoms that signal the need to seek medical attention.

URI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of upper respiratory track infection.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

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, e.g., decongestants, antihistamines, expectorants. Avoid aspirin in children under 16 years old due to the risk of Reyes' Syndrome.
2. Discuss the use of non-pharmacologic therapies that may be useful in symptom relief, e.g., nasal lavage, humidification of room, increasing oral fluids, gargling with warm salt water.

URI-L LITERATURE

OUTCOME: The patient/family will receive literature about upper respiratory infection.

STANDARDS:

1. Provide patient/family with literature on upper respiratory infection.
2. Discuss the content of the literature.

URI-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Explain that URIs (colds) are caused by viruses and that antibiotics are not effective.
    a. Discuss the use of over-the-counter medications, vitamin supplements, and herbal remedies for symptom relief, e.g., decongestants, antihistamines, expectorants.
2. Describe the name, strength, purpose, dosing directions, and storage of the medication.
3. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
4. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
5. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

URI-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
    a. Assessment of the nutrition related condition.
    b. Identification of the patient's nutritional problem.
    c. Identification of a specific nutrition intervention therapy plan.
    d. Evaluation of the patient's nutritional care outcomes.
    e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

URI-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.

URI-P PREVENTION

OUTCOME: The patient/family will have an understanding how to reduce the transmission of the common cold.

STANDARDS:

1. Discuss how viruses are transmitted and effective infection control measures, e.g., hand washing, reducing finger-to-face contact sneeze and cough into tissues, proper handling and/or disposal of contaminated items.
2. Discuss the use of surface disinfectants to keep kitchen and bathroom countertops clean. Wash children's toys. Don't share drinking glasses or utensils.
3. Explain that people with colds should avoid crowds, infants, elderly, and individuals with a chronic disease or compromised immune system.

UTI - Urinary Tract Infection

UTI-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand basic anatomy and function of the urinary tract and anatomical factors that can increase the risk for developing a UTI.

STANDARDS:

1. Discuss the basic anatomy and functions of the urinary system parts (urethra, bladder, ureters, and kidneys).
2. As appropriate to males and females, discuss the anatomical factors that increase a patient's risk of developing a UTI; e.g., urethral stricture, enlarged prostate, shorter urethra, or urethra located closer to the anus.

UTI-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology of urinary infections, common symptoms of urinary infections and factors that increase the risk for developing a UTI.

STANDARDS:

1. Explain that a UTI is an infection that can happen anywhere along the urinary tract. Discuss the cause of UTIs and how an infection in the urinary tract starts and progresses to the location of the infection.
2. Discuss factors that increase the risk for developing a urinary tract infection, e.g., bladder outlet obstruction, urine retention, urine reflux, hygiene factors, pelvic relaxation, pregnancy.
3. Explain that some people can have an infection and not have any symptoms. Discuss the most common signs and symptoms of a urinary tract infection, (e.g., dysuria, frequency, nocturia), and particular symptoms that may be present specific to the location of the infection; (e.g. flank pain, fever, chills).

UTI-FU FOLLOW-UP

OUTCOME: The patient and/or family will understand the importance of follow-up in the treatment of urinary tract infection.

STANDARDS:

1. Discuss the importance of follow-up care.

2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

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. Avoid feminine hygiene sprays, douches containing perfume.
   d. Keep the genital and anal areas clean before and after sex.
2. Discuss the role of foreskin hygiene as appropriate.
3. Discuss, as appropriate, the role of sexual intercourse in acquiring UTIs.

UTI-L LITERATURE

OUTCOME: The patient/family will receive literature about urinary tract infections.

STANDARDS:

1. Provide patient/family with literature on urinary tract infections.
2. Discuss the content of the literature.

UTI-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.

a. Inform patient/family that kidney damage is irreversible and special care needs to be taken to reduce the risk of recurrent infections.

2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

UTI-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

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, e.g., frequent urination, void after sexual intercourse, monogamy, drink plenty of water, eliminate bubble baths, avoid tight fitting pants, wear cotton-crotch underwear.

UTI-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain the pain scale and how it is used to assess the degree of pain individuals are experiencing. Discuss its use in developing a plan to manage pain.
2. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to "PM - Pain Management" on page 657.**
3. Explain the pharmalogical and non-pharmalogical measures that may be helpful to control the symptoms of pain, nausea and vomiting as applicable.

UTI-SM STRESS MANAGEMENT

OUTCOME: 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 healthy diet
   g. Exercising regularly
   h. Taking vacations
   i. Practicing meditation or prayer, self-hypnosis, and positive imagery
   j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   k. Participating in 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 and instructions that must be done prior to testing, e.g., NPO, have a full bladder, void prior to test.
4. Explain that follow-up tests may be ordered after completing treatment to be sure the infection is cured.

W

WH - Women's Health

WH-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the female breast, reproductive system, and genitalia.

STANDARDS:

1. Explain the normal anatomy and physiology of the breast. Discuss the areola, nipple, ducts, and glands.
2. Explain the normal anatomy and physiology of the female reproductive system. Identify the functions of the ovaries, ova, fallopian tubes, uterus, cervix, and vagina.
3. Explain the normal anatomy and physiology of the female genitalia. Identify the labia, vagina, and perineal area.

WH-BE BREAST EXAM

OUTCOME: The patient/patient will understand the importance of monthly breast self-examination, annual clinical breast exam, and mammograms as appropriate.

STANDARDS:

1. Discuss breast anatomy and the normal changes that occur with pregnancy, menstruation, and age.
2. Emphasize the importance of monthly breast self-examination in early detection of breast cancer. Survival rates are markedly higher when cancer is detected and treated early.
3. Teach breast self-exam. Have the patient give a return demonstration. Discuss normal findings, fibrocystic breast changes and warning signs to watch for with breast self-exam.
4. Discuss the importance of routine annual clinical examination. Emphasize that clinical breast exam (CBE) performed by a healthcare professional, such as a physician, nurse practitioner, or physician assistant should be part of a periodic health exam according to current screening guidelines.
5. Discuss indications for mammography and current recommendations for screening mammograms. Women at increased risk (e.g. family history, genetic tendency, past breast cancer) should discuss with their doctor the benefits and limitations of

starting mammography screening earlier, having additional tests, or having more frequent exams.

WH-COLP COLPOSCOPY

OUTCOME: The patient will understand the role of Colposcopy in identifying the degree of abnormality in an abnormal pap smear. The patient will understand the procedure and the importance of follow-up care in staying healthy.

STANDARDS:

1. Explain that colposcopy is a diagnostic tool used to evaluate the cervix for areas of abnormal tissue when a pap test was abnormal. Cells are visualized with a special instrument called a Colposcope.
    a. Explain that biopsy is often done during a Colposcopy exam to determine the degree of abnormality and to determine the best treatment plan.
2. Explain the role of Human Papilloma Virus in causing cells of the cervix to become abnormal. Explain that abnormality can be mild to severe, and if not treatment, the abnormal cells may progress to cancer.
3. Explain the risks, benefits, alternative, and results of non-treatment. Emphasize that the outlook is good with early diagnosis and treatment.
4. Explain that pain medication (e.g., ibuprofen) may be taken before arriving for the procedure to help minimize any pain during or following the procedure.
5. Review self-care following a biopsy, including bleeding, restrictions on sexual intercourse, and signs and symptoms of infection.
6. Explain that follow-up pap smears are often recommended to verify success of treatment and to detect any recurrence of abnormal cells.

WH-CRY CRYOTHERAPY

OUTCOME: The patient will understand the use of Cryotherapy in the treatment of abnormal areas of the cervix.

STANDARDS:

1. Discuss how cryotherapy is used to destroy small areas of abnormal cell growth on the cervix. It destroys abnormal areas by freezing them, allowing healthy cells to replace the abnormal cells.
2. Explain that cryotherapy may cause some mild cramping. Pain medication (e.g. ibuprofen) may be taken before arriving for the procedure to help minimize any pain during or following the procedure.

3. Review self-care following cryotherapy and the restrictions regarding sexual activity, tampons, and douching.
4. Reinforce the need to keep follow-up appointments and check-ups, as recommended by the provider.

WH-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, e.g., diet, exercise, sleep, stress management, hygiene, full participation in 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 healthcare 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.

WH-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity and will make a plan to increase regular activity by an agreed-upon amount if indicated.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Discuss obstacles to a personal exercise plan and solutions to those obstacles. Assist the patient in developing a personal exercise plan.

4. Encourage the patient to increase the intensity and duration of the activity as the patient becomes more fit.
5. Review general safety principles, e.g., warm-up first and cool down after exercise session, drink plenty of fluids, especially water, wear appropriate clothing and shoes, set realistic short-term and long-term goals.

WH-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up for women's health.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments and that follow-up appointments should be kept.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

WH-HY HYGIENE

OUTCOME: The patient will recognize good personal hygiene as an aspect of wellness.

STANDARDS:

1. Review aspects of good personal hygiene such as regular bathing, paying special attention to perineal area. Review the importance of wiping front to back to prevent bacterial contamination of the vagina and urethra.
2. **Refer to "HPDP-HY Hygiene" on page 481**.

WH-KE KEGEL EXERCISES

OUTCOME: The patient will understand how to use Kegel exercises to prevent urinary stress incontinence and improve pelvic muscle tone.

STANDARDS:

1. Review the basic pelvic floor anatomy.
2. Define stress incontinence and discuss its causes.
3. Teach Kegel exercises. Encourage frequent practice of Kegel exercises.

WH-L LITERATURE

OUTCOME: The patient/family will receive literature about women's health.

STANDARDS:

1. Provide the patient/family literature on women's health.
2. Discuss the content of the literature.

WH-LP LEEP

OUTCOME: The patient will understand the use of the Loop Electrosurgical Excision Procedure (LEEP) in the treatment of cervical dysplasia.

STANDARDS:

1. Explain that LEEP procedure is a method of treatment that destroys abnormal, precancerous cells on the "skin" of the cervix. The procedure uses a thin wire loop electrode that transmits a painless electrical current that cuts away affected cervical tissue.
2. Discuss patient preparation and positioning for the procedure. Discuss risks, benefits, alternative, and results of non-treatment.
3. Review self-care following LEEP, e.g., bleeding, cramping, pain, and any restrictions regarding sexual intercourse, daily activity, douching, use of tampons, tub baths.
4. Discuss follow-up instructions and the importance of keeping scheduled appointments to ensure the abnormal area was completely removed and it has not returned.

WH-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements.

Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

WH-MAM MAMMOGRAM

OUTCOME: The patient/family will understand the importance of screening mammograms, and what can be learned from the mammogram. The patient/family will further understand the risk of not having the mammogram performed.

STANDARDS:

1. Discuss the current recommendations for screening mammograms. Patients who have first degree relatives (mother, sister or daughter) with breast cancer are at higher risk and are encouraged to follow a risk-specific mammogram schedule. (Current as of 11/2005)
2. Discuss the indications for diagnostic mammography.
3. Discuss the risks and benefits of having routine mammography, and of finding lesions at the earliest stage. Discuss the risk of not having a mammogram performed.
4. Explain the process of having a mammogram, necessary preparations, the time to expect a report, and the recommended follow up.

WH-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of women's health.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Identification of a specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

WH-MP MENOPAUSE

OUTCOME: The patient/family will understand the etiology, symptomatology, and relief measures of menopause.

STANDARDS:

1. Explain that menopause simply means the end of monthly periods and marks the end of a woman's reproductive years. It isn't a single event, but a transition that can start in your 30s or 40s and last into your 50s or even 60s. **Refer to "MPS-DP Disease Process" on page 584.**
2. Explain that menopause begins naturally when the ovaries start making less estrogen and progesterone. Eventually menstrual periods stop, and women can no longer become pregnant.
3. Explain that pregnancy is still a risk and that contraception should be used until there has been no menses for 12 consecutive months.
4. Review how fluctuating hormone levels may result in the following physical and emotional symptoms, e.g., "hot flashes" (dilation of the blood vessels), headaches, dizziness, tachycardia, breast tenderness, fluid retention, decreased vaginal lubrication, unpredictable mood changes, sleep disturbances, fears about changing sexuality, anxiety, and depression. These symptoms are troublesome in approximately 20 percent of menopausal women.
5. Review relief measures which include hormone replacement therapy, vaginal lubricants, reducing salt and caffeine, staying active, and seeking psychological support as necessary.

WH-MS MENSES

OUTCOME: The patient will understand the menstrual cycle.

STANDARDS:

1. Discuss comfort measures for dysmenorrhea.
2. Discuss the importance of good menstrual hygiene. Discuss the use and frequent changing of tampons and napkins. Discourage use of super absorbent tampons.
3. Explain that exercise and sex need not be curtailed during menses but that additional hygiene measures should be taken.
4. Explain that it is normal for menstrual cycles to be irregular for several years after menarche.

WH-N NUTRITION

OUTCOME: The patient will relate diet to health promotion and disease prevention.

STANDARDS:

1. Discuss the patient's current nutritional habits. Stress dietary modifications and the importance of the food pyramid.
   a. Limit snack foods, fatty foods, red meats.
   b. Reduce sodium consumption, colas, coffee, and alcohol.
   c. Drink WATER.
   d. Add more fresh fruits, vegetables, and fiber.
   e. Get adequate intake of calcium in the diets. **Refer to "OS - Osteoporosis" on page 639**.
2. Review the relationship of calories to energy balance and body weight.
3. Review which community resources exist to assist with diet modification and weight control.
4. Stress the importance of being a smart shopper.

WH-OS OSTEOPOROSIS

OUTCOME: The patient will understand the etiology, symptomatology, prevention, and treatment of osteoporosis.

STANDARDS:

1. Discuss the causes of osteoporosis including loss of bone density secondary to reduced estrogen levels and low intake of calcium.
2. Emphasize the importance of prevention. Explain that peak bone density occurs about age 30 and that without intervention, progressive bone loss is typical.
3. Review the risk factors: Low dietary intake of calcium, sedentary lifestyle, familial history, smoking, stress, age over 40, gender, race, stature, and calcium binding medications such as laxatives, antacids, and steroids.
4. Emphasize that treatment is limited to preventing osteoporosis and/or slowing the progression of the disease. It is very important to prevent osteoporosis by a calcium-rich diet, regular weight-bearing exercise, decreased stress, not smoking, reduced alcohol intake, and estrogen replacement as appropriate.
5. Discuss the sequelae including stooped shoulders, loss of height, back, neck, and hip pain, and susceptibility to fractures.

WH-PAP PAP SMEAR

OUTCOME: The patient will understand the importance of routine Pap testing after onset of sexual activity or 18 years of age, whichever comes first.

STANDARDS:

1. Explain that the purpose of the Pap test is to screen for precancerous conditions.
2. Emphasize that precancerous conditions of the cervix are highly treatable.
3. Emphasize the importance of routine Pap tests (per screening guidelines for frequency). Encourage the patient to associate the Pap routine with an important date such as her birthday.
4. If this is the patient's first pap test, explain the procedure including positioning, placement of speculum, collection of cells, bimanual exam, and procedure for obtaining results of the pap test.
5. If this is other than an annual Pap test, explain the reason(s) for the test and the follow-up recommended. Discuss the results of the original test as appropriate.

WH-PMS PREMENSTRUAL SYNDROME

OUTCOME: The patient/family will understand the symptoms and relief measures for Premenstrual Syndrome (PMS).

STANDARDS:

1. Discuss Premenstrual Syndrome. Explain that it is a combination of physical and emotional symptoms resulting from fluctuations in the levels of estrogen and progesterone that occur 5–10 days before the onset of the menstrual period.
2. Review relief measures which include: physical activity, limiting intake of fat and salt, increasing water intake to 8 glasses daily, no limitation of sexual activity, supplemental vitamin B6 or calcium. Diuretics may help relieve some of the symptoms of PMS.

WH-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed procedure.
2. Explain the process and what to expect after the procedure.
3. Emphasize the importance of follow-up care.

WH-RS REPRODUCTIVE SYSTEM

OUTCOME: The patient/family will understand the normal anatomy and physiology of the female reproductive system.

STANDARDS:

1. Review the reproductive anatomy and discuss the reproductive cycle.
2. Discuss the importance of good hygiene.
3. Explain that sexually transmitted infections can impair fertility. **Refer to "STI - Sexually Transmitted Infections" on page 786**.
4. Because the risk of cervical cancer is increased by early sexual activity and multiple partners, encourage abstinence or monogamy as appropriate.

WH-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in overall health and well-being.

STANDARDS:

1. Explain that uncontrolled stress may cause release of stress hormones that interfere with general health and well-being.
2. 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 many disease states.
3. Explain that effective stress management may help prevent progression of many disease states. Discuss various stress management strategies that may help maintain a healthy lifestyle and improve health and well-being. 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 healthy diet
    g. Exercising regularly
    h. Taking vacations
    i. Practicing meditation, self-hypnosis, and positive imagery

j. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation

k. Participating in spiritual or cultural activities

4. Provide referrals as appropriate. Seek professional help as needed to reduce stress.

WH-STI SEXUALLY TRANSMITTED INFECTIONS (REFER TO CODES FOR STI)

WH-TD TRANSDERMAL (PATCH)

OUTCOME: The patient/family will understand the safe and effective use of transdermal contraception.

STANDARDS:

1. Discuss actions, risks, benefits, and common side effects of transdermal contraception and signs/symptoms of complications.
2. Discuss where the patch may be applied and the schedule of changing the patch. Explain how to handle missed, delayed, or misplaced patches.
3. Discuss when condom/barriers should be used as an additional precaution, such as initiation, obesity, missed doses, or drug/herbal interactions (antibiotics, anti-epileptics, or other medications) that reduce the effectiveness of the patch.
4. Explain that transdermal contraception can prevent pregnancy, if used correctly, but does not reduce the risk of sexually transmitted infections. Explain the need for follow-up, e.g., if pregnancy is suspected, menstrual cycle disturbances.

WH-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered and method of collection.
2. Explain the necessity, benefits, and risks of test(s) to be performed. Explain any potential risk of refusal of recommended test(s).
3. Inform patient of any advance preparation and instructions required for the test(s).
4. Explain that follow-up tests may be ordered based on the results.

Index of Codes

BURN	BURNS
BURN-C	Complications
BURN-CUL	Cultural/Spiritual Aspects of Health
BURN-DP	Disease Process
BURN-L	Literature
BURN-M	Medications
BURN-MNT	Medical Nutrition Therapy
BURN-N	Nutrition
BURN-P	Prevention
BURN-TX	Treatment
BURN-WC	Wound Care

CA	CANCER
CA-AD	Advance Directive
CA-AP	Anatomy and Physiology
CA-C	Complications
CA-CM	Case Management
CA-CUL	Cultural/Spiritual Aspects of Health
CA-DP	Disease Process
CA-EQ	Equipment
CA-FU	Follow-up
CA-HM	Home Management
CA-L	Literature
CA-LA	Lifestyle Adaptations
CA-M	Medications
CA-MNT	Medical Nutrition Therapy
CA-N	Nutrition
CA-P	Prevention
CA-PM	Pain Management
CA-REF	Referral
CA-SM	Stress Management
CA-TE	Tests
CA-TX	Treatment

CVA	CEREBROVASCULAR DISEASE
CVA-C	Complications
CVA-CM	Case Management
CVA-CUL	Cultural/Spiritual Aspects of Health
CVA-DP	Disease Process
CVA-EQ	Equipment
CVA-FU	Follow-up
CVA-HM	Home Management
CVA-L	Literature
CVA-LA	Lifestyle Adaptations
CVA-M	Medications
CVA-MNT	Medical Nutrition Therapy
CVA-N	Nutrition
CVA-P	Prevention
CVA-S	Safety and Injury Prevention
CVA-SM	Stress Management
CVA-TE	Tests
CVA-TX	Treatment

CWP	CHEMICAL WEAPONS
CWP-C	Complications
CWP-CM	Case Management
CWP-CUL	Cultural/Spiritual Aspects of Health
CWP-DP	Disease Process
CWP-FU	Follow-up
CWP-I	Information
CWP-L	Literature
CWP-M	Medications
CWP-MNT	Medical Nutrition Therapy
CWP-P	Prevention
CWP-TE	Tests
CWP-TX	Treatment

CHS CHILD HEALTH SCHOOL AGE (5-12 YEARS)

CHA CHILD HEALTH ADOLESCENT (12-18 YEARS)

CB CHILDBIRTH

CKD CHRONIC KIDNEY DISEASE

CPM	CHRONIC PAIN
CPM-CM	Case Management
CPM-CUL	Cultural/Spiritual Aspects of Health
CPM-DP	Disease Process
CPM-EQ	Equipment
CPM-EX	Exercise
CPM-FU	Follow-Up
CPM-IR	Information and Referral
CPM-L	Literature
CPM-LA	Lifestyle Adaptations
CPM-M	Medications
CPM-PSY	Psychotherapy
CPM-S	Safety
CPM-SM	Stress Management
CPM-TE	Tests
CPM-TX	Treatment

CDC	COMMUNICABLE DISEASES
CDC-AP	Anatomy and Physiology
CDC-C	Complications
CDC-DP	Disease Process
CDC-FU	Follow-up
CDC-EQ	Equipment
CDC-HM	Home Management
CDC-HY	Hygiene
CDC-L	Literature
CDC-M	Medications
CDC-MNT	Medical Nutrition Therapy
CDC-N	Nutrition
CDC-P	Prevention
CDC-PM	Pain Management
CDC-PRO	Procedures
CDC-TE	Tests
CDC-TX	Treatment

CHF	CONGESTIVE HEART FAILURE
CHF-C	Complications
CHF-CM	Case Management
CHF-CUL	Cultural/Spiritual Aspects of Health
CHF-DP	Disease Process
CHF-EQ	Equipment
CHF-EX	Exercise
CHF-FU	Follow-up
CHF-HM	Home Management
CHF-L	Literature
CHF-LA	Lifestyle Adaptations
CHF-M	Medications
CHF-MNT	Medical Nutrition Therapy
CHF-N	Nutrition
CHF-SM	Stress Management
CHF-TE	Tests

CAD	CORONARY ARTERY DISEASE
CAD-ADV	Advance Directive
CAD-C	Complications
CAD-CM	Case Management
CAD-CUL	Cultural/Spiritual Aspects of Health
CAD-DP	Disease Process
CAD-EQ	Equipment
CAD-EX	Exercise
CAD-FU	Follow-up
CAD-L	Literature
CAD-LA	Lifestyle Adaptations
CAD-M	Medications
CAD-MNT	Medical Nutrition Therapy
CAD-N	Nutrition
CAD-P	Prevention
CAD-PM	Pain Management
CAD-PRO	Procedures
CAD-SM	Stress Management
CAD-TE	Tests
CAD-TX	Treatment

HEAT HEATSTROKE

HEAT-C Complications
HEAT-CUL Cultural/Spiritual Aspects of Health
HEAT-DP Disease Process
HEAT-EX Exercise
HEAT-FU Follow-up
HEAT-L Literature
HEAT-M Medications
HEAT-MNT Medical Nutrition Therapy
HEAT-N Nutrition
HEAT-P Prevention
HEAT-TE Tests
HEAT-TX Treatment

HEP HEPATITIS A,B,C

HEP-AP Anatomy and Physiology
HEP-C Complications
HEP-CM Case Management
HEP-CUL Cultural/Spiritual Aspects of Health
HEP-DPA Disease Process Hepatitis A
HEP-DPB Disease Process Hepatitis B
HEP-DPC Disease Process Hepatitis C
HEP-FU Follow-up
HEP-L Literature
HEP-LA Lifestyle Adaptations
HEP-M Medications
HEP-MNT Medical Nutrition Therapy
HEP-N Nutrition
HEP-P Prevention
HEP-TE Tests
HEP-TX Treatment

HIV HUMAN IMMUNODEFICIENCY VIRUS

HIV-ADV Advance Directive
HIV-C Complications
HIV-CM Case Management
HIV-CUL Cultural/Spiritual Aspects of Health
HIV-DP Disease Process
HIV-EQ Equipment
HIV-FU Follow-up
HIV-HM Home Management
HIV-HY Hygiene
HIV-L Literature
HIV-LA Lifestyle Adaptations
HIV-M Medications
HIV-MNT Medical Nutrition Therapy
HIV-N Nutrition
HIV-P Prevention
HIV-PN Prenatal
HIV-S Safety
HIV-SM Stress Management
HIV-TE Tests
HIV-TX Treatment

LIP HYPERLIPIDEMIA / DYSLIPIDEMIAS

LIP-AP Anatomy and Physiology
LIP-C Complications
LIP-CM Case Management
LIP-CUL Cultural/Spiritual Aspects of Health
LIP-DP Disease Process
LIP-EX Exercise
LIP-FU Follow-up
LIP-L Literature
LIP-LA Lifestyle Adaptations
LIP-M Medications
LIP-MNT Medical Nutrition Therapy
LIP-N Nutrition
LIP-P Prevention
LIP-SM Stress Management
LIP-TE Tests
LIP-TX Treatment

PU	PRESSURE ULCER
PU-C	Complications
PU-CUL	Cultural/Spiritual Aspects of Health
PU-DP	Disease Process
PU-EQ	Equipment
PU-FU	Follow-up
PU-HM	Home Management
PU-L	Literature
PU-M	Medications
PU-MNT	Medical Nutrition Therapy
PU-N	Nutrition
PU-P	Prevention
PU-PM	Pain Management
PU-PRO	Procedures
PU-SCR	Screening
PU-TE	Tests
PU-TX	Treatment
PU-WC	Wound Care

PSR	PSORIASIS
PSR-BH	Behavioral Health
PSR-DP	Disease Process
PSR-FU	Follow-up
PSR-L	Literature
PSR-M	Medications
PSR-MNT	Medical Nutrition Therapy
PSR-N	Nutrition
PSR-P	Prevention
PSR-SM	Stress Management
PSR-TX	Treatment

PL	PULMONARY DISEASE
PL-ADV	Advance Directive
PL-BIP	Bilevel (or Continuous) Positive Airway Pressure Ventilation
PL-C	Complications
PL-CM	Case Management
PL-CUL	Cultural/Spiritual Aspects of Health
PL-DP	Disease Process
PL-EQ	Equipment
PL-EX	Exercise
PL-FU	Follow-up
PL-HM	Home Management
PL-INT	Intubation
PL-IS	Incentive Spirometry
PL-L	Literature
PL-LA	Lifestyle Adaptations
PL-M	Medications
PL-MDI	Metered-Dose Inhalers
PL-MNT	Medical Nutrition Therapy
PL-N	Nutrition
PL-NEB	Nebulizer
PL-O2	Oxygen Therapy
PL-PF	Peak-Flow Meter
PL-PM	Pain Management
PL-PRO	Procedures
PL-SHS	Second-Hand Smoke
PL-SPA	Spacers
PL-TE	Tests
PL-TO	Tobacco (Smoking)
PL-VENT	Mechanical Ventilation

XRAY	RADIOLOGY/NUCLEAR MEDICINE
XRAY-C	Complications
XRAY-EQ	Equipment
XRAY-FU	Follow-up
XRAY-L	Literature
XRAY-M	Medications
XRAY-PRO	Procedure
XRAY-S	Safety
XRAY-SCR	Screening
XRAY-TE	Tests

RSV RESPIRATORY SYNCYTIAL VIRUS

RSV-C Complications
RSV-DP Disease Process
RSV-FU Follow-up
RSV-HM Home Management
RSV-L Literature
RSV-M Medications
RSV-MNT Medical Nutrition Therapy
RSV-NEB Nebulizer
RSV-P Prevention
RSV-SHS Second-Hand Smoke
RSV-TE Tests
RSV-TO Tobacco (Smoking)

RST RESTRAINTS

RST-EQ Equipment
RST-L Literature
RST-M Medications
RST-S Safety and Injury Prevention

RA RHEUMATOID ARTHRITIS

RA-C Complications
RA-CM Case Management
RA-DP Disease Process
RA-EQ Equipment
RA-EX Exercise
RA-FU Follow-up
RA-L Literature
RA-LA Lifestyle Adaptations
RA-M Medications
RA-MNT Medical Nutrition Therapy
RA-N Nutrition
RD-PM Pain Management
RD-S Safety
RA-SM Stress Management
RA-TE Tests

SZ SEIZURE DISORDER

SZ-C Complications
SZ-CUL Cultural/Spiritual Aspects of Health
SZ-DP Disease Process
SZ-FU Follow-up
SZ-L Literature
SZ-LA Lifestyle Adaptations
SZ-M Medications
SZ-MNT Medical Nutrition Therapy
SZ-S Safety and Injury Prevention
SZ-SM Stress Management
SZ-TE Tests
SZ-TX Treatment

SARS SEVERE ACUTE RESPIRATORY SYNDROME

SARS-C Complications
SARS-DP Disease Process
SARS-FU Follow-up
SARS-HM Home Management
SARS-HY Hygiene
SARS-L Literature
SARS-LA Lifestyle Adaptations
SARS-M Medications
SARS-MNT Medical Nutrition Therapy
SARS-N Nutrition
SARS-P Prevention
SARS-TE Tests
SARS-TX Treatment

DIABETES CURRICULUM EDUCATION

DMC-ABC	Knowing Your Numbers (ABC)
DMC-AC	Acute Complications
DMC-BG	Behavioral Goals (Making Healthy Changes)
DMC-BGM	Blood Sugar Monitoring, Home
DMC-CC	Chronic Complications (Preventing and Treating Diabetes Complication)
DMC-DP	Disease Process (What Is Diabetes)
DMC-EX	Exercise (Moving to Stay Healthy)
DMC-FTC	Foot Care (Taking Care of Your Feet)
DMC-M	Diabetes Medicine Overview and Diabetes Pills
DMC-MSE	Mind, Spirit And Emotion
DMC-N	Nutrition (Basics of Healthy Eating)
DMC-PPC	Pre-Pregnancy Counseling
DMCN-FL	Nutrition (Session 1: Introduction to Food Labels)
DMCN-CC	Nutrition (Session 2: Introduction to Carbohydrate Counting)
DMCN-EL	Nutrition (Session 3: Introduction to Exchange Lists)
DMCN-FS	Nutrition (Session 4: Introduction to Food Shopping)
DMCN-HC	Nutrition (Session 5: Introduction to Healthy Cooking)
DMCN-EA	Nutrition (Session 6: Guidelines for Eating Away from Home)
DMCN-AL	Nutrition (Session 7: Guidelines for the Use of Alcohol)
DMCN-D	Nutrition (Session 8: Guidelines for Evaluating Diets)
DMCPG-DM	Session 1: Pregnancy, Diabetes and You: First Steps to a Healthy
DMCPG-N	Session 2: Healthy Eating During Pregnancy
DMCPG-EX	Session 3: Moving to Stay Healthy During Pregnancy
DMCPG-M	Session 4: Medicine During Pregnancy
DMCPG-BGM	Session 5: Home Blood Sugar Monitoring During Pregnancy
DMCPG-S	Session 6: Staying Healthy During Pregnancy
DMCPG-PP	Session 7: Staying Healthy After Delivery
GDMC-BG	Behavioral Goals (Making Healthy Changes
GDMC-BGM	Blood Sugar Monitoring, Home
GDMC-C	Complications
GDMC-DP	Disease Process
GDMC-EX	Exercise (Physical Activity and Pregnancy)
GDMC-FU	Follow-up
GDMC-L	Literature
GDMC-N	Nutrition (Meal Planning in Pregnancy)

GENERAL EDUCATION TOPICS

AP - Anatomy and Physiology
C - Complications
DP - Disease Process
EQ - Equipment
EX - Exercise
FU - Follow-up
HM - Home Management
HY - Hygiene
L - Literature
LA - Lifestyle Adaptations
M - Medications
MNT - Medical Nutrition Therapy
N - Nutrition
P - Prevention
PRO - Procedures
S - Safety
TE - Tests
TX - Treatment

EDUCATION NEEDS ASSESSMENT CODES

BAR-BLND	Blind
BAR-COGI	Cognitive Impairment
BAR-DEAF	Deaf
BAR-DNRE	Does Not Read English
BAR-EMOI	Emotional Impairment
BAR-FIMS	Fine Motor Skills Deficit
BAR-HEAR	Hard Of Hearing
BAR-INTN	Interpreter Needed
BAR-NONE	No Barriers
BAR-PEDI	Pediatric/Developmental
BAR-STRS	Social Stressors
BAR-VALU	Values/Belief
BAR-VISI	Visually Impaired
LP-GP	Group
LP-READ	Read
LP-MEDIA	Media
LP-TALK	Talk
RL-DSTR	Distraction
RL-EAGR	Eager To Learn
RL-RCPT	Receptive
RL-PAIN	Pain
RL-SVIL	Severity of Illness
RL-UNRC	Unreceptive