

INDIAN HEALTH SERVICE



Volume II

Patient and Family Education Protocols and Codes (PEPC)

18th Edition

effective date October 2011

About This Document

Volume 2 of the Patient Education manual contains the protocols and codes for patient education, what protocols changed, and the index of the protocols.

You can print this volume in its entirety or you can go to the IHS Web site and print individual protocols from the listing.

We have endeavored to try to make the Patient Education manual somewhat more manageable.

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New Codes for 2012

The following codes are new to the 2012 Patient Protocol and Coding Manual 18th edition.

ABNG ABUSE AND NEGLECT
[“ABNG-CUL Cultural/Spiritual Aspects of Health”](#)

ADJ ADJUSTMENT DISORDERS
[“ADJ-CUL Cultural/Spiritual Aspects of Health”](#)

[“ADJ-TLH Tele-Health”](#)

ADM ADMISSION TO HOSPITAL
[“ADM-CUL Cultural/Spiritual Aspects of Health”](#)

[“ADM-PM Pain Management”](#)

ADM ADMISSION TO HOSPITAL
[“AF-TLH Tele-Health”](#)

AOD ALCOHOL AND OTHER DRUGS
[“AOD-CUL Cultural/Spiritual Aspects of Health”](#)

[“AOD-FAS Fetal Alcohol Spectrum Disorders”](#)

ALZ ALZHEIMER’S DISEASE
[“ALZ-ADL Activities of Daily Living”](#)
[“ALZ-C Complications”](#)
[“ALZ-CUL Cultural/Spiritual Aspects of Health”](#)

[“ALZ-DP Disease Process”](#)

[“ALZ-HELP Help Line”](#)

[“ALZ-HM Home Management”](#)

[“ALZ-HPDP Health Promotion, Disease Prevention”](#)

[“ALZ-HY Hygiene”](#)

[“ALZ-S Safety”](#)

[“ALZ-TLH Tele-Health”](#)

Removed ALZ-LW

AMP AMPUTATIONS
[“AMP-CM Case Management”](#)

[“AMP-CUL Cultural/Spiritual Aspects of Health”](#)

ANS ANESTHESIA
[“ANS-PM Pain Management”](#)

ABXD ANTIBIOTIC ASSOCIATED DIARRHEA
[“ABXD-CUL Cultural/Spiritual Aspects of Health”](#)

ASM ASTHMA
[“ASM-CUL Cultural/Spiritual Aspects of Health”](#)

[“ASM-HELP Help Line”](#)

ATO AUTOIMMUNE DISORDERS
[“ATO-PM Pain Management”](#)

BH BEHAVIORAL AND SOCIAL HEALTH

[“BH-ADV Advance Directive”](#)

[“BH-CM Case Management”](#)

[“BH-DP Disease Process”](#)

[“BH-EQ Equipment”](#)

[“BH-EX Exercise”](#)

[“BH-GP Grieving Process”](#)

[“BH-HELP Help Line”](#)

[“BH-HM Home Management”](#)

[“BH-HY Hygiene”](#)

[“BH-LA Lifestyle Adaptations”](#)

[“BH-PA Parenting”](#)

[“BH-PRO Procedure”](#)

[“BH-RI Patient Rights and Responsibilities”](#)

[“BH-S Safety”](#)

[“BH-TLH Tele-Health”](#)

BELL BELL’S PALSY
[“BELL-HELP Help Line”](#)
[“BELL-PM Pain Management”](#)

BWP **BIOLOGICAL WEAPONS**
"BWP-CUL Cultural/Spiritual Aspects of Health"

BD **BIPOLAR DISORDERS**
"BD-CUL Cultural/Spiritual Aspects of Health"

BITE **BITES, ANIMAL AND HUMAN**
"BITE-C Complications"
"BITE-CUL Cultural/Spiritual Aspects of Health"
"BITE-HY Hygiene"
"BITE-P Prevention"
"BITE-PM Pain Management"
"BITE-TE Tests"
"BITE-WC Wound Care"

BF **BREASTFEEDING**
"BF-BB Benefits of Breastfeeding"
"BF-BC Breast Care"
"BF-CUL Cultural/Spiritual Aspects of Health"
"BF-EO Equipment"
"BF-GD Growth and Development"
"BF-HELP Help Line"
"BF-LA Lifestyle Adaptations"
"BF-M Maternal Medications"
"BF-MK Milk Intake"
"BF-ON Latch-On"

BURN **BURNS**
"BURN-CUL Cultural/Spiritual Aspects of Health"
"BURN-DP Disease Process"
"BURN-HY Hygiene"
"BURN-N Nutrition"
"BURN-P Prevention"
"BURN-PM Pain Management"
"BURN-WC Wound Care"

CA **CANCER**
"CA-CM Case Management"

"CA-CUL Cultural/Spiritual Aspects of Health"

"CA-EO Equipment"
"CA-EX Exercise"
"CA-FU Follow-up"
"CA-HELP Help Line"
"CA-HPDP Health Promotion, Disease Prevention"

"CA-HY Hygiene"
"CA-P Prevention"
"CA-PCC Pre-Conception Care"
"CA-PM Pain Management"
"CA-PRO Procedure"
"CA-REF Referral"
"CA-TX Treatment"

CELIAC **CELIAC DISEASE**
"CELIAC-AP Anatomy and Physiology"
"CELIAC-C Complications"
"CELIAC-HELP Help Line"
"CELIAC-L Literature"
"CELIAC-LA Lifestyle Adaptations"
"CELIAC-TX Treatment"

CERP **CEREBRAL PALSY**
"CERP-CUL Cultural/Spiritual Aspects of Health"
"CERP-PM Pain Management"

CVA **CEREBROVASCULAR DISEASE**
"CVA-CUL Cultural/Spiritual Aspects of Health"

CWP **CHEMICAL WEAPONS**
"CWP-AP Anatomy and Physiology"
"CWP-BH Behavioral and Emotional Health"
"CWP-C Complications"
"CWP-CUL Cultural/Spiritual Aspects of Health"
"CWP-DP Disease Process"
"CWP-EX Exercise"
"CWP-FU Follow-up"

[“CWP-HELP Help Line”](#)

[“CWP-L Literature”](#)

[“CWP-P Prevention and Decontamination”](#)

[“CWP-PM Pain Management”](#)

[“CWP-TE Tests”](#)

[“CWP-TX Treatment”](#)

[“CWP-WC Wound Care”](#)

Removed CWP-I

CP CHEST PAIN

[“CP-PM Pain Management”](#)

**CHN CHILD HEALTH NEWBORN
(0-60 DAYS)**

[“CHN-CUL Cultural/Spiritual Aspects of
Health”](#)

**CHI CHILD HEALTH INFANT (2-12
MONTHS)**

[“CHI-CUL Cultural/Spiritual Aspects of
Health”](#)

[“CHI-ECL Early Childhood Literacy”](#)

**CHT CHILD HEALTH TODDLER
(1-3 YEARS)**

[“CHT-CUL Cultural/Spiritual Aspects of
Health”](#)

[“CHT-ECL Early Childhood Literacy”](#)

**CHP CHILD HEALTH
PRESCHOOL (3-5 YEARS)**

[“CHP-CUL Cultural/Spiritual Aspects of
Health”](#)

[“CHP-ECL Early Childhood Literacy”](#)

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

[“CHS-CUL Cultural/Spiritual Aspects of
Health”](#)

[“CHS-ECL Early Childhood Literacy”](#)

**CHA CHILD HEALTH
ADOLESCENT (12-16 YEARS)**

[“CHA-CUL Cultural/Spiritual Aspects of
Health”](#)

CB CHILD BIRTH

[“CB-ADV Advance Directive”](#)

[“CB-BH Behavioral and Emotional Health”](#)

[“CB-CUL Cultural/Spiritual Aspects of
Health”](#)

[“CB-HELP Help Line”](#)

[“CB-HY Hygiene”](#)

[“CB-NJ Neonatal Jaundice”](#)

[“CB-VBAC Vaginal Birth after Cesarean
Section”](#)

CKD CHRONIC KIDNEY DISEASE

[“CKD-AP Anatomy and Physiology”](#)

[“CKD-C Complications”](#)

[“CKD-CUL Cultural/Spiritual Aspects of
Health”](#)

[“CKD-DIA Dialysis”](#)

[“CKD-DP Disease Process”](#)

[“CKD-EQ Equipment - Refer to “DIA -
Dialysis”](#)

[“CKD-FU Follow-up”](#)

[“CKD-HELP Help Line”](#)

[“CKD-LA Lifestyle Adaptations”](#)

[“CKD-M Medications”](#)

[“CKD-N Nutrition”](#)

[“CKD-P Prevention”](#)

[“CKD-PCC Pre-Conception Care”](#)

[“CKD-REF Referral”](#)

[“CKD-TX Treatment”](#)

**COPD CHRONIC OBSTRUCTIVE
PULMONARY DISEASE**

[“COPD-ADV Advance Directive”](#)

[“COPD-AP Anatomy and Physiology”](#)

[“COPD-BH Behavioral and Emotional
Health”](#)

[“COPD-C Complications”](#)

[“COPD-CM Case Management”](#)

[“COPD-CUL Cultural/Spiritual Aspects of
Health”](#)

[“COPD-DP Disease Process”](#)

[“COPD-EQ Equipment”](#)

[“COPD-EX Exercise”](#)

[“COPD-FU Follow-up”](#)

"COPD-HM Home Management"
"COPD-HY Hygiene"
"COPD-IS Incentive Spirometry"
"COPD-L Literature"
"COPD-LA Lifestyle Adaptations"
"COPD-M Medications"
"COPD-MDI Metered-Dose Inhalers"
"COPD-MNT Medical Nutrition Therapy"
"COPD-N Nutrition"
"COPD-P Prevention"
"COPD-PRO Procedure"
"COPD-SHS Second-Hand/Third-Hand
 Smoke"
"COPD-TE Tests"
"COPD-TO Tobacco (Smoking)"
"COPD-TX Treatment"

CPM CHRONIC PAIN
"CPM-CUL Cultural/Spiritual Aspects of
 Health"
"CPM-PM Pain Management"

COG COGNITIVE DISORDERS NOS
"COG-ADL Activities of Daily Living"
"COG-AP Anatomy and Physiology"
"COG-BH Behavioral and Emotional
 Health"
"COG-C Complications"
"COG-CM Case Management"
"COG-CUL Cultural/Spiritual Aspects of
 Health"
"COG-DP Disease Process"
"COG-FU Follow-up"
"COG-HELP Help Line"
"COG-HM Home Management"
"COG-HPDP Health Promotion, Disease
 Prevention"
"COG-L Literature"
"COG-LA Lifestyle Adaptations"
"COG-M Medications"
"COG-MNT Medical Nutrition Therapy"
"COG-N Nutrition"
"COG-S Safety"
"COG-SM Stress Management"

"COG-TE Tests"
"COG-TLH Tele-Health"
"COG-TX Treatment"

CRN CROHN'S DISEASE
"CRN-PCC Pre-Conception Care"

CDC COMMUNICABLE DISEASES
"CDC-PM Pain Management"

COND CONDUCT DISORDER
"COND-CUL Cultural/Spiritual Aspects of
 Health"
"COND-TLH Tele-Health"

CAD CORONARY ARTERY
 DISEASE
"CAD-CUL Cultural/Spiritual Aspects of
 Health"
"CAD-PM Pain Management"

CRIT CRITICAL CARE
"CRIT-ADV Advance Directive"
"CRIT-BH Behavioral and Emotional
 Health"
"CRIT-BIP Bilevel (or Continuous) Positive
 Airway Pressure Ventilation"
"CRIT-C Complications"
"CRIT-CM Case Management"
"CRIT-CUL Cultural/Spiritual Aspects of
 Health"
"CRIT-DIA Dialysis"
"CRIT-EO Equipment"
"CRIT-FU Follow-up"
"CRIT-HY Hygiene"
"CRIT-INT Intubation"
"CRIT-IS Incentive Spirometry"
"CRIT-ISO Isolation"
"CRIT-L Literature"
"CRIT-LA Lifestyle Adaptations"
"CRIT-M Medications"
"CRIT-MNT Medical Nutrition Therapy"
"CRIT-MON Monitoring"
"CRIT-N Nutrition"

[“CRIT-O2 Oxygen Therapy”](#)

[“CRIT-P Prevention”](#)

[“CRIT-PM Pain Management”](#)

[“CRIT-PRO Procedure”](#)

[“CRIT-PT Physical Therapy”](#)

[“CRIT-S Safety”](#)

[“CRIT-SM Stress Management”](#)

[“CRIT-TE Tests”](#)

[“CRIT-TX Treatment”](#)

[“CRIT-WC Wound Care”](#)

CRN CROHN’S DISEASE

[“CRN-CUL Cultural/Spiritual Aspects of Health”](#)

[“CRN-HELP Help Line”](#)

[“CRN-PM Pain Management”](#)

CF CYSTIC FIBROSIS

[“CF-CUL Cultural/Spiritual Aspects of Health”](#)

[“CF-HELP Help Line”](#)

DEH DEHYDRATION

[“DEH-AP Anatomy and Physiology”](#)

[“DEH-DP Disease Process”](#)

[“DEH-HPDP Health Promotion, Disease Prevention”](#)

[“DEH-TX Treatment”](#)

Removed DEH-EQ, DEH-HM, DEH-TE

DEL DELIRIUM

[“DEL-CUL Cultural/Spiritual Aspects of Health”](#)

DEM DEMENTIA

[“DEM-ADL Activities of Daily Living”](#)

[“DEM-C Complications”](#)

[“DEM-CUL Cultural/Spiritual Aspects of Health”](#)

[“DEM-HM Home Management”](#)

[“DEM-L Literature”](#)

[“DEM-LA Lifestyle Adaptations”](#)

[“DEM-S Safety”](#)

[“DEM-TLH Tele-Health”](#)

[“DEM-TX Treatment”](#)

DC DENTAL CARIES

[“DC-AP Anatomy and Physiology”](#)

[“DC-C Complications”](#)

[“DC-DP Disease Process”](#)

[“DC-P Prevention”](#)

[“DC-PM Pain Management”](#)

DEP DEPRESSIVE DISORDERS

[“DEP-C Complications”](#)

[“DEP-CM Case Management”](#)

[“DEP-CUL Cultural/Spiritual Aspects of Health”](#)

[“DEP-DP Disease Process”](#)

[“DEP-EX Exercise”](#)

[“DEP-FU Follow-up”](#)

[“DEP-HELP Help Line”](#)

[“DEP-LA Lifestyle Adaptations”](#)

[“DEP-P Prevention”](#)

[“DEP-S Safety”](#)

[“DEP-TLH Tele-Health”](#)

[“DEP-TX Treatment”](#)

Removed DEP-PCC

DM DIABETES MELLITUS

[“DM-CUL Cultural/Spiritual Aspects of Health”](#)

[“DM-HELP Help Line”](#)

[“DM-LA Lifestyle Adaptations”](#)

DIA DIALYSIS

[“DIA-ADV Advance Directive”](#)

[“DIA-AP Anatomy and Physiology”](#)

[“DIA-C Complications”](#)

[“DIA-CUL Cultural/Spiritual Aspects of Health”](#)

[“DIA-EQ Equipment”](#)

[“DIA-HELP Help Line”](#)

[“DIA-HM Home Management”](#)

[“DIA-HY Hygiene”](#)

[“DIA-N Nutrition”](#)

[“DIA-P Prevention”](#)

[“DIA-REF Referral”](#)

“DIA-TX Treatment”

Removed DIA-PCC

DCH DISCHARGE FROM HOSPITAL

“DCH-BH Behavioral and Emotional Health”

“DCH-CM Case Management”

“DCH-HELP Help Line”

“DCH-REF Referral”

DISSD DISSOCIATIVE DISORDERS

“DISSD-CUL Cultural/Spiritual Aspects of Health”

“DISSD-TLH Tele-Health”

DVP DOMESTIC VIOLENCE, PERPETRATOR

“DVP-CUL Cultural/Spiritual Aspects of Health”

DVV DOMESTIC VIOLENCE - VICTIM

“DVV-CUL Cultural/Spiritual Aspects of Health”

DYS DYSRHYTHMIAS

“DYS-C Complications”

“DYS-DP Disease Process”

“DYS-EO Equipment”

“DYS-HELP Help Line”

“DYS-REF Referral”

“DYS-TX Treatment”

ECC EARLY CHILDHOOD CARIES

“ECC-AP Anatomy and Physiology”

“ECC-C Complications”

“ECC-DP Disease Process”

“ECC-HY Hygiene”

“ECC-L Literature”

“ECC-LA Lifestyle Adaptations”

“ECC-N Nutrition”

“ECC-P Prevention”

“ECC-PM Pain Management”

EAT EATING DISORDER

“EAT-CUL Cultural/Spiritual Aspects of Health”

“EAT-TLH Tele-Health”

ECZ ECZEMA/ATOPIC DERMATITIS

“ECZ-CUL Cultural/Spiritual Aspects of Health”

ELD ELDER CARE

“ELD-CM Case Management”

“ELD-CUL Cultural/Spiritual Aspects of Health”

“ELD-DP Disease Process/Aging”

“ELD-S Safety”

ENC ENCEPHALITIS

“ENC-ADV Advance Directive”

“ENC-AP Anatomy and Physiology”

“ENC-BH Behavioral and Emotional Health”

“ENC-C Complications”

“ENC-CM Case Management”

“ENC-CUL Cultural/Spiritual Aspects of Health”

“ENC-DP Disease Process”

“ENC-EO Equipment”

“ENC-EX Exercise”

“ENC-FU Follow-up”

“ENC-HELP Help Line”

“ENC-HM Home Management”

“ENC-HPDP Health Promotion, Disease Prevention”

“ENC-HY Hygiene”

“ENC-L Literature”

“ENC-LA Lifestyle Adaptations”

“ENC-M Medications”

“ENC-MNT Medical Nutrition Therapy”

“ENC-N Nutrition”

“ENC-P Prevention”

“ENC-PM Pain Management”

“ENC-PRO Procedure”

“ENC-PSY Psychotherapy”

[“ENC-SM Stress Management”](#)

[“ENC-TE Tests”](#)

[“ENC-TLH Tele-Health”](#)

[“ENC-TX Treatment”](#)

ENCOP ENCOPRESIS

[“ENCOP-CUL Cultural/Spiritual Aspects of Health”](#)

[“ENCOP-HELP Help Line”](#)

EOL END OF LIFE

[“EOL-CUL Cultural/Spiritual Aspects of Health”](#)

ENU ENURESIS (BEDWETTING)

[“ENU-CUL Cultural/Spiritual Aspects of Health”](#)

FACT FACTITIOUS DISORDER

[“FACT-CUL Cultural/Spiritual Aspects of Health”](#)

FTT FAILURE TO THRIVE (ALL AGES)

[“FTT-CUL Cultural/Spiritual Aspects of Health”](#)

FALL FALL

[“FALL-AP Anatomy and Physiology”](#)

[“FALL-BH Behavioral and Emotional Health”](#)

[“FALL-C Complications”](#)

[“FALL-CC Cast Care”](#)

[“FALL-DP Disease Process”](#)

[“FALL-EO Equipment”](#)

[“FALL-EX Exercise”](#)

[“FALL-HM Home Management”](#)

[“FALL-HPDP Health Promotion, Disease Prevention”](#)

[“FALL-LA Lifestyle Adaptations”](#)

[“FALL-P Prevention”](#)

[“FALL-PM Pain Management”](#)

[“FALL-SCR Screening”](#)

[“FALL-TX Treatment”](#)

[“FALL-WC Wound Care”](#)

FP FAMILY PLANNING

[“FP-CUL Cultural/Spiritual Aspects of Health”](#)

FEED FEEDING DISORDERS OF INFANCY OR EARLY CHILDHOOD

[“FEED-BH Behavioral and Emotional Health”](#)

[“FEED-C Complications”](#)

[“FEED-CM Case Management”](#)

[“FEED-CUL Cultural/Spiritual Aspects of Health”](#)

[“FEED-DP Disease Process”](#)

[“FEED-FU Follow-up”](#)

[“FEED-HELP Help Line”](#)

[“FEED-HM Home Management”](#)

[“FEED-HPDP Health Promotion, Disease Prevention”](#)

[“FEED-L Literature”](#)

[“FEED-LA Lifestyle Adaptations”](#)

[“FEED-M Medications”](#)

[“FEED-MNT Medical Nutrition Therapy”](#)

[“FEED-N Nutrition”](#)

[“FEED-P Prevention”](#)

[“FEED-PA Parenting”](#)

[“FEED-PSY Psychotherapy”](#)

[“FEED-SM Stress Management”](#)

[“FEED-TE Tests”](#)

[“FEED-TLH Tele-Health”](#)

[“FEED-TX Treatment”](#)

FASD FETAL ALCOHOL SYNDROME

[“FASD-AOD Alcohol and Other Drugs”](#)

FMS FIBROMYALGIA SYNDROME

[“FMS-CUL Cultural/Spiritual Aspects of Health”](#)

[“FMS-DP Disease Process”](#)

[“FMS-EX Exercise”](#)

[“FMS-FU Follow-up”](#)

["FMS-LA Lifestyle Adaptations"](#)
["FMS-M Medications"](#)
["FMS-N Nutrition"](#)
["FMS-PM Pain Management"](#)
["FMS-PSY Psychotherapy"](#)
["FMS-TE Tests"](#)
["FMS-TX Treatment"](#)
FOOT FOOT/PODIATRIC DISORDERS
["FOOT-PM Pain Management"](#)
FRST FROSTBITE
["FRST-PM Pain Management"](#)
GB GALLBLADDER DISORDERS
["GB-PM Pain Management"](#)
GE GASTROENTERITIS
["GE-CUL Cultural/Spiritual Aspects of Health"](#)
["GE-PM Pain Management"](#)
GER GASTROESOPHAGEAL REFLUX DISEASE
["GER-PM Pain Management"](#)
GENDR GENDER IDENTITY DISORDER
["GENDR-C Complications"](#)
["GENDR-CM Case Management"](#)
["GENDR-CUL Cultural/Spiritual Aspects of Health"](#)
["GENDR-DP Disease Process"](#)
["GENDR-FU Follow-up"](#)
["GENDR-HELP Help Line"](#)
["GENDR-HPDP Health Promotion, Disease Prevention"](#)
["GENDR-L Literature"](#)
["GENDR-LA Lifestyle Adaptations"](#)
["GENDR-M Medications"](#)
["GENDR-PSY Psychotherapy"](#)
["GENDR-S Safety"](#)
["GENDR-SM Stress Management"](#)

["GENDR-TLH Tele-Health"](#)
["GENDR-TX Treatment"](#)
GAD GENERALIZED ANXIETY DISORDER
["GAD-CUL Cultural/Spiritual Aspects of Health"](#)
["GAD-TLH Tele-Health"](#)
GDM GESTATIONAL DIABETES
["GDM-AP Anatomy And Physiology"](#)
["GDM-CUL Cultural/Spiritual Aspects of Health"](#)
["GDM-HPDP Health Promotion, Disease Prevention"](#)
["GDM-L Literature"](#)
["GDM-LA Lifestyle Adaptations"](#)
["GDM-MNT Medical Nutrition Therapy"](#)
["GDM-N Nutrition"](#)
["GDM-PRO Procedure"](#)
["GDM-REF Referral"](#)
["GDM-SCR Screening"](#)
["GDM-SHS Second-Hand/Third-Hand Smoke"](#)
["GDM-SM Stress Management"](#)
GIB GI BLEED
["GIB-CUL Cultural/Spiritual Aspects of Health"](#)
GOUT GOUT
["GOUT-CUL Cultural/Spiritual Aspects of Health"](#)
["GOUT-PM Pain Management"](#)
GRIEF GRIEF
["GRIEF-CUL Cultural/Spiritual Aspects of Health"](#)
["GRIEF-TLH Tele-Health"](#)
GBS GUILLAIN-BARRE SYNDROME
["GBS-PM Pain Management"](#)

LICE HEAD LICE

["LICE-BH Behavioral and Emotional Health"](#)

["LICE-C Complications"](#)

["LICE-DP Disease Process"](#)

["LICE-HM Home Management"](#)

["LICE-HY Hygiene"](#)

["LICE-M Medications"](#)

["LICE-P Prevention"](#)

["LICE-TX Treatment"](#)

HA HEADACHES

["HA-C Complications"](#)

["HA-DP Disease Process"](#)

["HA-EX Exercise"](#)

["HA-FU Follow-up"](#)

["HA-HELP Help Line"](#)

["HA-LA Lifestyle Adaptations"](#)

["HA-N Nutrition"](#)

["HA-PM Pain Management"](#)

["HA-SM Stress Management"](#)

Removed HA-PSY

**HPDP HEALTH PROMOTION,
DISEASE PREVENTION**

["HPDP-BH Behavioral and Emotional Health"](#)

["HPDP-CAR Automobile Safety"](#)

["HPDP-CUL Cultural/Spiritual Aspects of Health"](#)

["HPDP-HY Hygiene"](#)

["HPDP-LA Lifestyle Adaptations"](#)

["HPDP-M Medications"](#)

["HPDP-S Safety"](#)

["HPDP-SM Stress Management"](#)

["HPDP-SX Sexuality"](#)

Removed HPDP-PSY

HF HEART FAILURE

["HF-ADV Advance Directive"](#)

["HF-CUL Cultural/Spiritual Aspects of Health"](#)

["HF-DCHL Discharge Literature"](#)

["HF-EX Exercise"](#)

["HF-HELP Help Line"](#)

["HF-HM Home Management"](#)

["HF-LA Lifestyle Adaptations"](#)

["HF-N Nutrition"](#)

["HF-P Prevention"](#)

["HF-PRO Procedure"](#)

["HF-SHS Second-Hand/Third-Hand Smoke"](#)

["HF-SM Stress Management"](#)

["HF-TLH Tele-Health"](#)

["HF-TO Tobacco"](#)

["HF-TX Treatment"](#)

HEAT HEATSTROKE

["HEAT-CUL Cultural/Spiritual Aspects of Health"](#)

HEM HEMORRHOIDS

["HEM-AP Anatomy and Physiology"](#)

["HEM-C Complications"](#)

["HEM-CUL Cultural/Spiritual Aspects of Health"](#)

["HEM-DP Disease Process"](#)

["HEM-EX Exercise"](#)

["HEM-FU Follow-up"](#)

["HEM-HM Home Management"](#)

["HEM-HPDP Health Promotion, Disease Prevention"](#)

["HEM-HY Hygiene"](#)

["HEM-L Literature"](#)

["HEM-LA Lifestyle Adaptations"](#)

["HEM-M Medications"](#)

["HEM-MNT Medical Nutrition Therapy"](#)

["HEM-N Nutrition"](#)

["HEM-P Prevention"](#)

["HEM-PM Pain Management"](#)

["HEM-PRO Procedure"](#)

["HEM-SM Stress Management"](#)

["HEM-TE Tests"](#)

["HEM-TX Treatment"](#)

HEP HEPATITIS A,B,C

["HEP-C Complications"](#)

["HEP-DPA Disease Process Hepatitis A"](#)

“HEP-DPC Disease Process Hepatitis C”
“HEP-FU Follow-up”
“HEP-HM Home Management”
“HEP-HPDP Health Promotion, Disease Prevention”
“HEP-L Literature”
“HEP-LA Lifestyle Adaptations”
“HEP-P Prevention”
“HEP-PCC Pre-Conception Care”
“HEP-PRO Procedure”
“HEP-TX Treatment”

IV HOME IV THERAPY
“IV-CUL Cultural/Spiritual Aspects of Health”
“IV-PM Pain Management”
“IV-TLH Tele-Health”

LIP HYPERLIPIDEMIA/
DYSLIPIDEMIAS
“LIP-CUL Cultural/Spiritual Aspects of Health”
“LIP-TLH Tele-Health”

HTN HYPERTENSION
“HTN-C Complications”
“HTN-CUL Cultural/Spiritual Aspects of Health”
“HTN-HELP Help Line”
“HTN-SCR Screening”
“HTN-SHS Second-Hand/Third-Hand Smoke”
“HTN-TLH Tele-Health”
“HTN-TX Treatment”

HTH HYPERTHYROIDISM
“HTH-AP Anatomy and Physiology”
“HTH-CUL Cultural/Spiritual Aspects of Health”
“HTH-DP Disease Process”
“HTH-HELP Help Line”

Removed HTH-SCR

HPTH HYPOTHERMIA
“HPTH-CUL Cultural/Spiritual Aspects of Health”

IMPLS IMPULSE CONTROL
DISORDERS
“IMPLS-CUL Cultural/Spiritual Aspects of Health”
“IMPLS-HELP Help Line”
“IMPLS-TLH Tele-Health”

FLU INFLUENZA
“FLU-CUL Cultural/Spiritual Aspects of Health”
“FLU-PM Pain Management”

INJ INJURIES
“INJ-PM Pain Management”

JRA JUVENILE RHEUMATOID
ARTHRITIS
“JRA-CUL Cultural/Spiritual Aspects of Health”
“JRA-HELP Help Line”
“JRA-HY Hygiene”
“JRA-L Literature”
“JRA-N Nutrition”
“JRA-PM Pain Management”
“JRA-TLH Tele-Health”
“JRA-TX Treatment”

STONES KIDNEY STONES
“STONES-PM Pain Management”

LD LEARNING DISORDERS/
DISABILITIES
“LD-CUL Cultural/Spiritual Aspects of Health”
“LD-TLH Tele-Health”

LIV LIVER DISEASE
“LIV-CUL Cultural/Spiritual Aspects of Health”
“LIV-HELP Help Line”

LYME LYME DISEASE

[“LYME-TLH Tele-Health”](#)

LOMA LYMPHOMA

[“LOMA-ADV Advance Directive”](#)
[“LOMA-AP Anatomy and Physiology”](#)
[“LOMA-BH Behavioral and Emotional Health”](#)
[“LOMA-C Complications”](#)
[“LOMA-CM Case Management”](#)
[“LOMA-CUL Cultural/Spiritual Aspects of Health”](#)
[“LOMA-DP Disease Process”](#)
[“LOMA-EQ Equipment”](#)
[“LOMA-EX Exercise”](#)
[“LOMA-FU Follow-up”](#)
[“LOMA-HELP Help Line”](#)
[“LOMA-HM Home Management”](#)
[“LOMA-HPDP Health Promotion, Disease Prevention”](#)
[“LOMA-HY Hygiene”](#)
[“LOMA-L Literature”](#)
[“LOMA-LA Lifestyle Adaptations”](#)
[“LOMA-M Medications”](#)
[“LOMA-MNT Medical Nutrition Therapy”](#)
[“LOMA-N Nutrition”](#)
[“LOMA-P Prevention”](#)
[“LOMA-PCC Pre-Conception Care”](#)
[“LOMA-PM Pain Management”](#)
[“LOMA-PRO Procedure”](#)
[“LOMA-SHS Second-Hand/Third-Hand Smoke”](#)
[“LOMA-SM Stress Management”](#)
[“LOMA-TE Tests”](#)
[“LOMA-TLH Tele-Health”](#)
[“LOMA-TX Treatment”](#)
[“LOMA-WC Wound Care”](#)

MSAF MEDICAL SAFETY

[“MSAF-M Medications”](#)

M MEDICATIONS

[“M-ADD Addition”](#)

[“M-DI Drug Interaction”](#)

[“M-FU Follow-up”](#)

[“M-I Information”](#)

[“M-MB Medication Box Teaching”](#)

[“M-MDI Metered-Dose Inhalers”](#)

[“M-MR Medication Reconciliation”](#)

[“M-S Safety”](#)

[“M-TE Tests”](#)

Removed M-PRX

MNG MENINGITIS

[“MNG-ADV Advance Directive”](#)

[“MNG-AP Anatomy and Physiology”](#)

[“MNG-BH Behavioral and Emotional Health”](#)

[“MNG-C Complications”](#)

[“MNG-CM Case Management”](#)

[“MNG-CUL Cultural/Spiritual Aspects of Health”](#)

[“MNG-DP Disease Process”](#)

[“MNG-EQ Equipment”](#)

[“MNG-EX Exercise”](#)

[“MNG-FU Follow-up”](#)

[“MNG-HELP Help Line”](#)

[“MNG-HM Home Management”](#)

[“MNG-HPDP Health Promotion, Disease Prevention”](#)

[“MNG-HY Hygiene”](#)

[“MNG-L Literature”](#)

[“MNG-LA Lifestyle Adaptations”](#)

[“MNG-M Medications”](#)

[“MNG-MNT Medical Nutrition Therapy”](#)

[“MNG-N Nutrition”](#)

[“MNG-P Prevention”](#)

[“MNG-PM Pain Management”](#)

[“MNG-PRO Procedure”](#)

[“MNG-PSY Psychotherapy”](#)

[“MNG-SM Stress Management”](#)

[“MNG-TE Tests”](#)

[“MNG-TLH Tele-Health”](#)

[“MNG-TX Treatment”](#)

MH MEN'S HEALTH

["MH-CUL Cultural/Spiritual Aspects of Health"](#)

MPS MENOPAUSE

["MPS-CUL Cultural/Spiritual Aspects of Health"](#)

["MPS-HELP Help Line"](#)

MNTL MENTAL HEALTH

["MNTL-AM Anger Management"](#)

["MNTL-AS Assertiveness Skills"](#)

["MNTL-CD Cognitive Distortions"](#)

["MNTL-COM Communication Skills"](#)

["MNTL-COP Coping Skills"](#)

["MNTL-CR Conflict Resolution"](#)

["MNTL-DEF Defences/Resistance"](#)

["MNTL-FI Feeling Identification"](#)

["MNTL-GP Grieving Process"](#)

["MNTL-HPDP Health Promotion, Disease Prevention"](#)

["MNTL-L Literature"](#)

["MNTL-PA Parenting"](#)

["MNTL-PSY Psychotherapy"](#)

["MNTL-REL Interpersonal Relationships"](#)

["MNTL-SM Stress Management"](#)

MR MENTAL RETARDATION

["MR-CUL Cultural/Spiritual Aspects of Health"](#)

["MR-TLH Tele-Health"](#)

MSX METABOLIC SYNDROME

["MSX-AP Anatomy and Physiology"](#)

["MSX-BH Behavioral and Emotional Health"](#)

["MSX-C Complications"](#)

["MSX-CM Case Management"](#)

["MSX-CUL Cultural/Spiritual Aspects of Health"](#)

["MSX-DP Disease Process"](#)

["MSX-EQ Equipment"](#)

["MSX-EX Exercise"](#)

["MSX-HPDP Health Promotion, Disease Prevention"](#)

["MSX-L Literature"](#)

["MSX-LA Lifestyle Adaptations"](#)

["MSX-M Medications"](#)

["MSX-N Nutrition"](#)

["MSX-P Prevention"](#)

["MSX-PCC Pre-Conception Care"](#)

["MSX-REF Referral"](#)

["MSX-TE Tests"](#)

["MSX-SM Stress Management"](#)

["MSX-TLH Tele-Health"](#)

["MSX-TX Treatment"](#)

MDRO MULTIDRUG-RESISTANT ORGANISM

["MDRO-CUL Cultural/Spiritual Aspects of Health"](#)

MD MUSCULAR DYSTROPHY

["MD-CUL Cultural/Spiritual Aspects of Health"](#)

["MD-PM Pain Management"](#)

["MD-TLH Tele-Health"](#)

ND NEUROLOGIC DISORDER

["ND-CUL Cultural/Spiritual Aspects of Health"](#)

NOSE NOSE BLEED (EPISTAXIS)

["NOSE-AP Anatomy And Physiology"](#)

["NOSE-C Complications"](#)

["NOSE-DP Disease Process"](#)

["NOSE-L Literature"](#)

["NOSE-PRO Procedures"](#)

OBS OBESITY

["OBS-CUL Cultural/Spiritual Aspects of Health"](#)

["OBS-HELP Help Line"](#)

OCD OBSESSIVE-COMPULSIVE DISORDER

["OCD-C Complications"](#)

“OCD-CM Case Management”
“OCD-CUL Cultural/Spiritual Aspects of Health”

“OCD-DP Disease Process”
“OCD-FU Follow-up”
“OCD-HY Hygiene”
“OCD-L Literature”
“OCD-LA Lifestyle Adaptations”
“OCD-PSY Psychotherapy”
“OCD-S Safety”
“OCD-SM Stress Management”
“OCD-TLH Tele-Health”
“OCD-TX Treatment”

OCC OCCUPATIONAL HEALTH

“OCCU-PM Pain Management”

ODM OCULAR DIABETES MELLITUS

“ODM-AP Anatomy and Physiology”
“ODM-BH Behavioral and Emotional Health”
“ODM-C Complications”
“ODM-CM Case Management”
“ODM-DP Disease Process”
“ODM-EX Exercise”
“ODM-FU Follow-up”
“ODM-HM Home Management”
“ODM-LA Lifestyle Adaptations”
“ODM-PM Pain Management”
“ODM-PRO Procedure”
“ODM-S Safety”
“ODM-TE Tests”
“ODM-TX Treatment”

ODD OPPOSITIONAL DEFIANT DISORDER

“ODD-CUL Cultural/Spiritual Aspects of Health”
“ODD-TLH Tele-Health”

TPLNT ORGAN DONATION/ TRANSPLANT

“TPLNT-CUL Cultural/Spiritual Aspects of Health”
“TPLNT-PM Pain Management”
“TPLNT-TLH Tele-Health”

OA OSTEOARTHRITIS

“OA-CUL Cultural/Spiritual Aspects of Health”
“OA-DP Disease Process”
“OA-EQ Equipment”
“OA-EX Exercise”
“OA-HELP Help Line”
“OA-HM Home Management”
“OA-HPDP Health Promotion, Disease Prevention”
“OA-HY Hygiene”
“OA-L Literature”
“OA-LA Lifestyle Adaptations”
“OA-N Nutrition”
“OA-PM Pain Management”
“OA-PT Physical Therapy”
“OA-S Safety”
“OA-SM Stress Management”
“OA-TE Tests”
“OA-TX Treatment”

OS OSTEOPOROSIS

“OS-CUL Cultural/Spiritual Aspects of Health”
“OS-HELP Help Line”
“OS-PM Pain Management”

OM OTITIS MEDIA

“OM-C Complications”
“OM-DP Disease Process”
“OM-FU Follow-up”
“OM-HM Home Management”
“OM-LA Lifestyle Adaptations”
“OM-P Prevention”
“OM-PRO Procedure”
“OM-REF Referral”

[“OM-SHS Second-Hand/Third-Hand
Smoke”](#)

[“OM-TE Tests”](#)

[“OM-TX Treatment”](#)

PM PAIN MANAGEMENT

[“PM-CUL Cultural/Spiritual Aspects of
Health”](#)

PC PANCREATITIS

[“PC-CUL Cultural/Spiritual Aspects of
Health”](#)

[“PC-HELP Help Line”](#)

[“PC-PM Pain Management”](#)

PANIC PANIC DISORDER

[“PANIC-CUL Cultural/Spiritual Aspects of
Health”](#)

[“PANIC-TLH Tele-Health”](#)

PNL PERINATAL LOSS

[“PNL-CUL Cultural/Spiritual Aspects of
Health”](#)

[“PNL-PM Pain Management”](#)

PERIO PERIODONTAL DISEASE

[“PERIO-AP Anatomy and Physiology”](#)

[“PERIO-DP Disease Process”](#)

[“PERIO-FU Follow-up”](#)

[“PERIO-N Nutrition”](#)

[“PERIO-PM Pain Management”](#)

**PVD PERIPHERAL VASCULAR
DISEASE**

[“PVD-ADV Advance Directive”](#)

[“PVD-C Complications”](#)

[“PVD-CM Case Management”](#)

[“PVD-CUL Cultural/Spiritual Aspects of
Health”](#)

[“PVD-DP Disease Process”](#)

[“PVD-EX Exercise”](#)

[“PVD-FU Follow-up”](#)

[“PVD-HELP Help Line”](#)

[“PVD-L Literature”](#)

[“PVD-LA Lifestyle Adaptations”](#)

[“PVD-MNT Medical Nutrition Therapy”](#)

[“PVD-N Nutrition”](#)

[“PVD-P Prevention”](#)

[“PVD-PM Pain Management”](#)

[“PVD-REF Referral”](#)

[“PVD-SCR Screening”](#)

[“PVD-SHS Second-Hand/Third-Hand
Smoke”](#)

[“PVD-WC Wound Care”](#)

PERSD PERSONALITY DISORDER

[“PERSD-CUL Cultural/Spiritual Aspects of
Health”](#)

[“PERSD-TLH Tele-Health”](#)

**PDD PERVASIVE
DEVELOPMENTAL
DISORDERS**

[“PDD-CUL Cultural/Spiritual Aspects of
Health”](#)

[“PDD-HELP Help Line”](#)

[“PDD-TLH Tele-Health”](#)

PHOB PHOBIAS

[“PHOB-CUL Cultural/Spiritual Aspects of
Health”](#)

[“PHOB-HELP Help Line”](#)

PNM PNEUMONIA

[“PNM-CUL Cultural/Spiritual Aspects of
Health”](#)

[“PNM-PM Pain Management”](#)

PP POSTPARTUM

[“PP-CUL Cultural/Spiritual Aspects of
Health”](#)

PDEP POSTPARTUM DEPRESSION

[“PDEP-C Complications”](#)

[“PDEP-CM Case Management”](#)

[“PDEP-CUL Cultural/Spiritual Aspects of
Health”](#)

[“PDEP-DP Disease Process”](#)

[“PDEP-FU Follow-up”](#)

[“PDEP-L Literature”](#)

[“PDEP-M Medications”](#)

[“PDEP-P Prevention”](#)

[“PDEP-S Safety”](#)

[“PDEP-TX Treatment”](#)

**PTSD POSTTRAUMATIC STRESS
DISORDER**

[“PTSD-CUL Cultural/Spiritual Aspects of
Health”](#)

PDM PREDIABETES

[“PDM-AP Anatomy And Physiology”](#)

[“PDM-C Complications”](#)

[“PDM-CM Case Management”](#)

[“PDM-CUL Cultural/Spiritual Aspects of
Health”](#)

[“PDM-DP Disease Process”](#)

[“PDM-EX Exercise”](#)

[“PDM-HPDP Health Promotion, Disease
Prevention”](#)

[“PDM-N Nutrition”](#)

[“PDM-P Prevention”](#)

[“PDM-PCC Pre-Conception Care”](#)

[“PDM-TLH Tele-Health”](#)

[“PDM-TX Treatment”](#)

PN PRENATAL

[“PN-CUL Cultural/Spiritual Aspects of
Health”](#)

[“PN-HELP Help Line”](#)

PU PRESSURE ULCERS

[“PU-CUL Cultural/Spiritual Aspects of
Health”](#)

[“PU-PM Pain Management”](#)

PSYD PSYCHOTIC DISORDERS

[“PSYD-CUL Cultural/Spiritual Aspects of
Health”](#)

[“PSYD-TLH Tele-Health”](#)

PL PULMONARY DISEASE

[“PL-CUL Cultural/Spiritual Aspects of
Health”](#)

[“PL-PM Pain Management”](#)

PYELO PYELONEPHRITIS

[“PYELO-TX Treatment”](#)

**XRAY RADIOLOGY/NUCLEAR
MEDICINE**

[“XRAY-PM Pain Management”](#)

**REACT REACTIVE ATTACHMENT
DISORDER**

[“REACT-CUL Cultural/Spiritual Aspects
of Health”](#)

[“REACT-TLH Tele-Health”](#)

**RST RESTRAINTS AND
SECLUSION**

[“RST-PM Pain Management”](#)

RA RHEUMATOID ARTHRITIS

[“RA-CUL Cultural/Spiritual Aspects of
Health”](#)

[“RA-EO Equipment”](#)

[“RA-EX Exercise”](#)

[“RA-HM Home Management”](#)

[“RA-HELP Help Line”](#)

[“RA-HPDP Health Promotion, Disease
Prevention”](#)

[“RA-HY Hygiene”](#)

[“RA-LA Lifestyle Adaptations”](#)

[“RA-M Medications”](#)

[“RA-N Nutrition”](#)

[“RA-PM Pain Management”](#)

[“RA-PT Physical Therapy”](#)

[“RA-TLH Tele-Health”](#)

[“RA-TX Treatment”](#)

SARC SARCOIDOSIS

[“SARC-AP Anatomy and Physiology”](#)

[“SARC-BH Behavioral and Emotional
Health”](#)

[“SARC-C Complications”](#)
[“SARC-CM Case Management”](#)
[“SARC-CUL Cultural/Spiritual Aspects of Health”](#)
[“SARC-DP Disease Process”](#)
[“SARC-EO Equipment”](#)
[“SARC-EX Exercise”](#)
[“SARC-FU Follow-up”](#)
[“SARC-HELP Help Line”](#)
[“SARC-HM Home Management”](#)
[“SARC-HPDP Health Promotion, Disease Prevention”](#)
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[“SARC-L Literature”](#)
[“SARC-LA Lifestyle Adaptations”](#)
[“SARC-M Medications”](#)
[“SARC-MNT Medical Nutrition Therapy”](#)
[“SARC-N Nutrition”](#)
[“SARC-PCC Pre-Conception Care”](#)
[“SARC-PM Pain Management”](#)
[“SARC-PRO Procedure”](#)
[“SARC-SHS Second-Hand/Third-Hand Smoke”](#)
[“SARC-SM Stress Management”](#)
[“SARC-TE Tests”](#)
[“SARC-TLH Tele-Health”](#)
[“SARC-TX Treatment”](#)
[“SARC-WC Wound Care”](#)

SZ SEIZURE DISORDER
[“SZ-CUL Cultural/Spiritual Aspects of Health”](#)
[“SZ-HELP Help Line”](#)

SEP SEPARATION ANXIETY DISORDER
[“SEP-CUL Cultural/Spiritual Aspects of Health”](#)
[“SEP-HELP Help Line”](#)
[“SEP-TLH Tele-Health”](#)

SEX SEXSINUSITISUAL DISORDERS

[“SEX-CUL Cultural/Spiritual Aspects of Health”](#)

STI SEXUALLY TRANSMITTED INFECTIONS

[“STI-C Complications”](#)
[“STI-DP Disease Process”](#)
[“STI-FU Follow-up”](#)
[“STI-HELP Help Line”](#)
[“STI-P Prevention”](#)
[“STI-SM Stress Management”](#)
[“STI-TE Tests”](#)
[“STI-TX Treatment”](#)

SHI SHINGLES
[“SHI-EX Exercise”](#)
[“SHI-HELP Help Line”](#)
[“SHI-HPDP Health Promotion, Disease Prevention”](#)
[“SHI-P Prevention”](#)
[“SHI-TE Tests”](#)

SINUS SINUSITIS
[“SINUS-CUL Cultural/Spiritual Aspects of Health”](#)
[“SINUS-HELP Help Line”](#)

SWI SKIN AND WOUND INFECTIONS
[“SWI-CUL Cultural/Spiritual Aspects of Health”](#)
[“SWI-EX Exercise”](#)
[“SWI-PM Pain Management”](#)

SLEEP SLEEP DISORDERS
[“SLEEP-CUL Cultural/Spiritual Aspects of Health”](#)
[“SLEEP-TLH Tele-Health”](#)

SNAKE SNAKE BITE
[“SNAKE-CUL Cultural/Spiritual Aspects of Health”](#)

“SNAKE-PM Pain Management”

SOMA SOMATOFORM DISORDERS

“SOMA-CUL Cultural/Spiritual Aspects of Health”

“SOMA-PM Pain Management”

“SOMA-TLH Tele-Health”

ST SORE THROAT

“ST-CUL Cultural/Spiritual Aspects of Health”

“ST-PM Pain Management”

SPIDER SPIDER BITE

“SPIDER-PM Pain Management”

STING STING, INSECT

“STING-L Literature”

“STING-PM Pain Management”

“STING-WC Wound Care”

Removed STING-HY

SIDS SUDDEN INFANT DEATH SYNDROME

“SIDS-CUL Cultural/Spiritual Aspects of Health”

SI SUICIDAL IDEATION AND GESTURES

“SI-C Complications”

“SI-CM Case Management”

“SI-CUL Cultural/Spiritual Aspects of Health”

“SI-DP Disease Process”

“SI-FU Follow-up”

“SI-HELP Help Line”

“SI-L Literature”

“SI-M Medications”

“SI-P Prevention”

“SI-PSY Psychotherapy”

“SI-S Safety”

“SI-TX Treatment”

SPE SURGICAL PROCEDURES AND ENDOSCOPY

“SPE-CUL Cultural/Spiritual Aspects of Health”

TICD TIC DISORDERS

“TICD-C Complications”

“TICD-CM Case Management”

“TICD-CUL Cultural/Spiritual Aspects of Health”

“TICD-DP Disease Process”

“TICD-EX Exercise”

“TICD-FU Follow-up”

“TICD-HELP Help Line”

“TICD-HPDP Health Promotion, Disease Prevention”

“TICD-L Literature”

“TICD-LA Lifestyle Adaptations”

“TICD-M Medications”

“TICD-PSY Psychotherapy”

“TICD-SM Stress Management”

“TICD-TLH Tele-Health”

“TICD-TX Treatment”

TO TOBACCO USE

“TO-FU Follow-up”

“TO-REL Relapse Prevention”

“TO-OT Quit”

TB TUBERCULOSIS

“TB-CUL Cultural/Spiritual Aspects of Health”

“TB-HELP Help Line”

UC ULCERATIVE COLITIS

“UC-C Complications”

“UC-CM Case Management”

“UC-CUL Cultural/Spiritual Aspects of Health”

“UC-HELP Help Line”

“UC-HPDP Health Promotion, Disease Prevention”

“UC-HY Hygiene”

“UC-LA Lifestyle Adaptations”

[“UC-N Nutrition”](#)

[“UC-P Prevention”](#)

[“UC-PM Pain Management”](#)

[“UC-PRO Procedure”](#)

[“UC-TE Tests”](#)

[“UC-TX Treatment”](#)

URI UPPER RESPIRATORY
TRACK INFECTION

[“URI-CUL Cultural/Spiritual Aspects of Health”](#)

UTI URINARY TRACT
INFECTION

[“UTI-CUL Cultural/Spiritual Aspects of Health”](#)

[“UTI-PM Pain Management”](#)

UCATH URINARY CATHETER AND
ASSOCIATED INFECTION

[“UCATH-AP Anatomy and Physiology”](#)

[“UCATH-C Complications”](#)

[“UCATH-DP Disease Process”](#)

[“UCATH-EQ Equipment”](#)

[“UCATH-FU Follow-up”](#)

[“UCATH-HM Home Management”](#)

[“UCATH-HY Hygiene”](#)

[“UCATH-L Literature”](#)

[“UCATH-LA Lifestyle Adaptations”](#)

[“UCATH-M Medications”](#)

[“UCATH-P Prevention”](#)

[“UCATH-PM Pain Management”](#)

[“UCATH-PRO Procedure”](#)

[“UCATH-S Safety”](#)

[“UCATH-TE Tests”](#)

[“UCATH-TX Treatment”](#)

VENT VENTILATION
(MECHANICAL) AND
ASSOCIATED PNEUMONIA

[“VENT-ADV Advance Directive”](#)

[“VENT-AP Anatomy and Physiology”](#)

[“VENT-C Complications”](#)

[“VENT-DP Disease Process”](#)

[“VENT-EQ Equipment”](#)

[“VENT-EX Exercise”](#)

[“VENT-HY Hygiene”](#)

[“VENT-INT Intubation”](#)

[“VENT-L Literature”](#)

[“VENT-M Medications”](#)

[“VENT-MNT Medical Nutrition Therapy”](#)

[“VENT-N Nutrition”](#)

[“VENT-P Prevention”](#)

[“VENT-PM Pain Management”](#)

[“VENT-PRO Procedure”](#)

[“VENT-S Safety”](#)

[“VENT-TE Tests”](#)

[“VENT-TX Treatment”](#)

[“VENT-VAP Ventilator-Associated Pneumonia”](#)

WH WOMEN’S HEALTH

[“WH-CUL Cultural/Spiritual Aspects of Health”](#)

YEAST YEAST INFECTION

[“YEAST-CUL Cultural/Spiritual Aspects of Health”](#)

[“YEAST-HELP Help Line”](#)

[“YEAST-PM Pain Management”](#)

A**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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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 the 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

ABD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand 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.

STANDARDS:

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, the expected benefits, and the risk of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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.

ABNG - Abuse and Neglect (child or elder)

ABNG-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to abuse and neglect.

STANDARDS:

1. Discuss the common difficulty in coping with the impact of abuse and neglect, which may require a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, or other emotional reactions that are common in being diagnosed with abuse and neglect, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#).**
6. Refer to a mental health agency or provider.

ABNG-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in cases of suspected abuse and neglect.

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”](#).**

ABNG-C COMPLICATIONS

OUTCOME: The patient/family will understand the effects and consequences of abuse and neglect.

STANDARDS:

1. Discuss that abuse and neglect may result in death, serious physical, or emotional harm to the victim.
2. Explain that abuse and neglect are actions punishable by law.

ABNG-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

ABNG-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in abuse and neglect cases.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

ABNG-IR INFORMATION AND REFERRAL

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

STANDARDS:

1. Emphasize the importance of reporting suspected incidents of abuse and neglect to the patient's healthcare provider and the proper adult protective and law enforcement agencies.

2. Provide the patient/family with assistance in securing alternative or additional resources as needed, such as parenting classes, including a list of any private and public community agencies that can provide or arrange for assessment and care of individuals/families involved in abuse and neglect.
3. Emphasize the importance of securing appropriate medical care, behavioral health services, and social services for victims of child abuse and their families with an emphasis of immediate safety and medical needs of the victim.

ABNG-L LITERATURE

OUTCOME: The patient/family will receive literature about abuse and neglect.

STANDARDS:

1. Provide the patient/family with literature on abuse and neglect, which may include safety procedures (**refer to [“ABNG-S Safety”](#)**), and a list of private and public treatment programs.
2. Discuss the content of the literature.

ABNG-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to abuse and neglect.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the use of food as a coping mechanism and its role in eating disorders.
4. Refer to registered dietitian for MNT or other local resources as appropriate.

ABNG-P PREVENTION

OUTCOME: The patient/family will understand ways of preventing abuse and neglect.

STANDARDS:

1. Explain that education about abuse and neglect to potential victims (child and elders) and caretakers is an essential part of prevention.
2. Explain that parenting classes may help develop skills for preventing emotional and behavioral complications (**refer to [“ABNG-PA Parenting”](#)**).
3. Refer to Behavioral Health or Social Services for caretaker skills, as needed.

ABNG-PA PARENTING

OUTCOME: The patient/family will understand parenting skills necessary to meet the physical and emotional needs of children, thereby reducing the risk of child abuse/neglect.

STANDARDS:

1. Discuss methods for appropriate parenting at home.
2. Emphasize the importance of communicating in a way that the child understands.
3. Discuss the importance of providing emotional support and unconditional assistance to the child.
4. Refer the family to mental health services/ family counseling if the family is becoming overwhelmed.

ABNG-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of abuse and neglect.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

ABNG-RI PATIENT RIGHTS AND RESPONSIBILITIES

OUTCOME: The patient/family will understand the rights and responsibilities of victims, reporters, and potential assailants.

STANDARDS:

1. Discuss patient rights to privacy and confidentiality as it relates to patient/family safety and mandatory reporting laws for providers, as appropriate.
2. Discuss that all persons have the right to a life free of abuse and neglect.
3. Identify methods and resources to enhance patient safety. For elder abuse, find ways of maintaining the patient's autonomy and independence as appropriate.

ABNG-RP MANDATORY REPORTING

OUTCOME: The patient/family will understand the process of mandatory reporting.

STANDARDS:

1. Emphasize the importance of reporting suspected abuse and neglect to the proper law enforcement and child welfare/protective agencies and the patient's healthcare provider.
2. Explain that mandatory reporting is necessary to ensure the safety of all children and adults.
3. Explain that requirements for mandatory reporting vary by state. Some states require reporting for "reasonable cause to believe" while others require reported for "known or suspected" abuse or neglect.
4. Explain that states require healthcare provider, mental healthcare providers, teachers, social workers, day care providers, and law enforcement personnel to report suspected abuse or neglect.
5. Explain that failure to report such information may result in criminal or civil liability for the provider.

ABNG-S SAFETY

OUTCOME: The patient/family will understand safety when dealing with abuse and neglect situations.

STANDARDS:

1. Discuss the behaviors that constitute abuse and neglect, and help define safe and healthy ways of intervening with victim(s).
2. Emphasize the importance of reporting suspected abuse and neglect. **Refer to ["ABNG-RP Mandatory Reporting"](#).**
3. Assist to develop a plan of action that will ensure safety of all people in the environment of violence.
4. Explain the need for the family to develop a safety plan for the victim(s).

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 scarring.
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. Discuss that the most common distribution of acne is the face, neck, chest, back, shoulders, and upper arms.
5. Discuss that some people are more prone to develop acne because of hereditary factors.
6. Explain that the role of stress of acne is not elucidated.

ACNE-FU FOLLOW UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

ACNE-HELPHELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding Acne.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding Acne and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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 acne.

STANDARDS:

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

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. 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, proper storage, and food/drug and drug/drug interactions. Discuss any barriers to full participation including requirements for isotretinoin therapy.
5. Discuss common and important side effects, home management, and side effects that should prompt follow-up.

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.

ADJ - Adjustment Disorders

ADJ-C COMPLICATIONS

OUTCOME: The patient/family will understand any complications that may result from Adjustment Disorders.

STANDARDS:

1. Explain that the presence of an Adjustment Disorder may complicate the course of a general medical condition or illness, e.g., decreased compliance with medical recommendations or increased length of hospital stays.
2. Explain that an Adjustment Disorder may worsen and develop into another major Axis I or Axis II Disorder, including Depressive Disorders (**refer to [“DEP - Depressive Disorders”](#)**), Anxiety Disorders, Alcohol or Drug Addiction (**refer to [“AOD - Alcohol and Other Drugs”](#)**), Posttraumatic Stress Disorder (**refer to [“PTSD - Posttraumatic Stress Disorder”](#)**), or Personality Disorders (**refer to [“PERSD - Personality Disorder”](#)**).
3. Explain that teenagers with Adjustment Disorders, especially those with chronic stressors and symptoms, are at risk for developing long-term serious mental illnesses, such as Bipolar Disorder (**refer to [“BD - Bipolar Disorders”](#)**), Schizophrenia (**refer to [“PSYD - Psychotic Disorders”](#)**), or Antisocial Personality Disorder (**refer to [“PERSD - Personality Disorder”](#)**).
4. Explain that adjustment disorders are associated with increased risk of suicide, especially if left untreated.

ADJ-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

ADJ-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of Adjustment Disorder.

STANDARDS:

1. Explain the essential symptoms and features of Adjustment Disorders, including:
 - a. The development of emotional and behavioral symptoms in response to an identifiable stressor(s).
 - b. These symptoms or behaviors are in excess of what would be expected from exposure to the stressor.
2. Discuss the stressor(s) are at the root of the illness or disorder, which may be a single event (e.g. the termination of a romantic relationship), or may be multiple stressors (e.g. marked marital and business difficulties).
3. Discuss the associated features of Adjustment Disorders frequently manifested, such as decreased work performance or temporary changes in social relationships.
4. Explain that the course of an Adjustment Disorder always begins within three months of the onset of the stressor(s) and may last indefinitely depending on the duration of the presence of the stressor(s).
5. Explain that Adjustment Disorders could be present cyclically with those suffering from exacerbations of other chronic illnesses.

ADJ-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in alleviating stress and symptoms of Adjustment Disorder.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

ADJ-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.

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.

ADJ-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding the specific stressor(s).

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding the stressor(s).
2. Provide the help line phone number or Internet address (URL).

ADJ-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

ADJ-L LITERATURE

OUTCOME: The patient/family will receive literature about Adjustment Disorders.

STANDARDS:

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

ADJ-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary to prevent further complications or exacerbations.

STANDARDS:

1. Discuss lifestyle adaptations specific to stressor(s) raised by the patient, as well as coping strategies to prevent future stress or exacerbations (**refer to [“ADJ-SM Stress Management”](#)**).
2. Discuss that family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

ADJ-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

ADJ-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to coping with stressful life events.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

ADJ-P PREVENTION

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

STANDARDS:

1. Explain and discuss ways of developing and enhancing specific internal coping strategies, resiliency, and stress management techniques (**refer to [“ADJ-SM Stress Management”](#)**), which may include seeking out humor or laughter, living a healthy lifestyle (i.e., appropriate exercise, diet, meditation), and thinking positively about oneself.
2. Discuss the importance of developing and enhancing appropriate external support systems and resources.
3. Discuss ways of avoiding stressful situations that may lead to significant distress.

ADJ-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of Adjustment Disorder.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

ADJ-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to problems or issues and the potential for them to worsen.

STANDARDS:

1. Discuss/ review the safety plan with the patient and family, including the no-harm contract and emergency procedures should the condition worsen, suicidal or homicidal ideation arise, and/or urges to engage in risky/dangerous behavior arise.
2. Review the local resources and phone numbers, including the police that may be utilized during a crisis, and may assist in transportation and safety compliance.

ADJ-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in coping with the stressor(s) and preventing complications.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in coping with the stressor(s) and preventing complications.
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.

ADJ-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

ADJ-TX TREATMENT

OUTCOME: The patient/family will understand the options that may be used to treat Adjustment Disorder.

STANDARDS:

1. Explain that individual psychotherapy is the treatment of choice for Adjustment Disorders because the symptoms are an understandable reaction to a specific stress:
 - a. Explain that most people recover completely from Adjustment Disorders, especially if they have had no previous history of mental illness, and have a stable home life with a strong support system.
 - b. Explain that couples or marital therapy may be helpful for those whose symptoms are caused or exacerbated by the relationship.
 - c. Explain that self-help groups aimed at specific problems, e.g. recovering from job loss or divorce, can be extremely helpful to people suffering from Adjustment Disorders.
2. Explain that medication interventions are not usually prescribed for Adjustment Disorders, although anti-depressants or anti-anxiety medications may be prescribed in conjunction to therapy for short periods to improve sleep or overall functioning.
3. Explain that therapists have different styles and orientations for treating Adjustment Disorders, and that some styles may suit the patient better than others. Explain that therapy usually involves:
 - a. Developing or enhancing coping skills
 - a. Understanding how the stressor effected their lives

- a. Developing alternate social or recreational activities
4. Explain that the treatment plan will be made by the patient and treatment team after reviewing available options. Explain that treatment for Adjustment Disorders may vary according to the patient's life circumstances, severity of the condition, and available resources.

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 Indian Health System.
 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-IB INSURANCE AND BENEFITS

OUTCOME: The patient/family will understand healthcare services and resources available as it relates to insurance and benefits.

STANDARDS:

1. Explain that many individuals qualify for direct payments and/or reimbursement for health care and related costs from certain programs.
2. Explain that direct payments include services that:
 - a. Are provided at the health care facility at no cost to the patient.
 - b. Are provided at other health care facilities through contract health services.
 - i. Contract services are services that Indian Health Systems facilities cannot always provide.
 - ii. They may require a referral to non-Indian Health Systems facilities.
3. Explain that in addition to Indian Health Systems, the other available programs include:
 - a. Medicare: a national healthcare program that covers people 65 years of age and older, individuals younger than 65 who are disabled or with end stage renal disease, and retired railroad employees.
 - i. Medicare Part A: Inpatient hospital services, skilled nursing facilities, home health and hospice care.
 - ii. Medicare Part B: Outpatient hospital services, doctors, certain medical equipment and other items not covered under Part A.

- iii. Medicare Part D: Prescription medication and Medication Therapy Management (MTM) service coverage.
- b. Social Security Disability Insurance
- c. State Children's Health Insurance Programs (SCHIP)
- d. Supplemental Security Income (SSI)
- e. Veterans Administration (VA)
- f. Medicaid that provides resources to help pay for medical and long-term care assistance
- g. Private Health Plans
- h. Women, Infants, and Children (WIC)
- i. State/federal aid for disabled children
- j. Temporary Assistance for Needy Families (TANF)
4. Explain that a Benefits Coordinator is knowledgeable about federal and state programs and is a resource to help a patients determine program eligibility
5. Review and explain applications for identifiable services.
6. Explain that Indian Health Systems services can be enhanced due to revenue collected when a patient enrolls in additional health care resource.

AF-ISEC INFANT SECURITY

OUTCOME: The patient/family will have basic understand of necessary infant security measures.

STANDARDS:

1. Explain the infant security measures that have been implemented to decrease the chances of infant abduction from this facility.
2. Explain the role and responsibilities parents and visitors have for maintaining infant security.

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. 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.

AF-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

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 guiding medical care and decision making to best serve the patient's care preferences.

STANDARDS:

1. Explain that many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is unable to provide guidance at the time that decisions need to be made.
3. Explain that Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences for care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer,) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.
6. Refer to ["ADV - Advance Directives"](#).

ADM-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences of 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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 O₂, 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-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to infection prevention in the hospital.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

ADM-IB INSURANCE AND BENEFITS

OUTCOME: The patient/family will understand healthcare services and resources available as it relates to insurance and benefits.

STANDARDS:

1. Explain that many individuals qualify for direct payments and/or reimbursement for health care and related costs from certain programs.
2. Explain that direct payments include services that:
 - a. Are provided at the health care facility at no cost to the patient.
 - b. Are provided at other health care facilities through contract health services.
 - i. Contract services are services that Indian Health Systems facilities cannot always provide.
 - ii. They may require a referral to non-Indian Health Systems facilities.
3. Explain that in addition to Indian Health Systems, the other available programs include:
 - a. Medicare: a national healthcare program that covers people 65 years of age and older, individuals younger than 65 who are disabled or with end stage renal disease, and retired railroad employees.
 - i. Medicare Part A: Inpatient hospital services, skilled nursing facilities, home health and hospice care.
 - ii. Medicare Part B: Outpatient hospital services, doctors, certain medical equipment and other items not covered under Part A.
 - iii. Medicare Part D: Prescription medication and Medication Therapy Management (MTM) service coverage.
 - b. Social Security Disability Insurance
 - c. State Children's Health Insurance Programs (SCHIP)
 - d. Supplemental Security Income (SSI)
 - e. Veterans Administration (VA)
 - f. Medicaid that provides resources to help pay for medical and long-term care assistance
 - g. Private Health Plans
 - h. Women, Infants, and Children (WIC)
 - i. State/federal aid for disabled children
 - j. Temporary Assistance for Needy Families (TANF)
4. Explain that a Benefits Coordinator is knowledgeable about federal and state programs and is a resource to help a patient determine program eligibility

5. Review and explain applications for identifiable services.
6. Explain that Indian Health Systems services can be enhanced due to revenue collected when a patient enrolls in additional health care resource.

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. Demonstrate how the bed controls work.
3. Identify the telephone (if available) and explain how to place calls and how incoming calls will be received. Explain any restrictions on telephone use.
4. Explain the reason for and use of bed side rails in the hospital setting. Discuss the hospital policy regarding side rails as appropriate.
5. Explain the unit visiting policies, including any restrictions to visitation.
6. 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 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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

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”](#).
 - 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-RRT RAPID RESPONSE TEAM

OUTCOME: The patient/family will understand how and when to summon the rapid response team.

STANDARDS:

1. Inform the patient/family of the availability of the rapid response team that will respond, assess, and initiate treatment, as necessary, if the patient’s condition rapidly deteriorates.
2. Instruct the patient/family regarding the appropriate criteria for summoning the rapid response team and the mechanism for making the notification.

ADM-S SAFETY

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"**](#).

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 the patient/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-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to the use of alcohol or other drugs of abuse.

STANDARDS:

1. Explain the normal anatomy and physiology of the brain, liver, and other organs affected by alcohol or other drugs, as appropriate.
2. Discuss the changes to anatomy and physiology as a result of alcohol or other drugs.
3. Discuss the impact of these changes on the patient's health or well-being.

AOD-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to alcohol or other drug use.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with alcohol or other drug as a life-altering illness that requires a change in lifestyle (refer to [“AOD-LA Lifestyle Adaptations”](#)).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with alcohol or other drug abuse or dependence, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs.
6. Refer to a mental health agency or provider.

AOD-BNI BRIEF NEGOTIATED INTERVENTION

Screening follow-up is critical to reducing risk for hazardous or harmful alcohol use. The Brief Negotiated Interview has been established as a best practice intervention tool for hazardous or harmful drinkers as outlined in the IHS best practice protocol, the Alcohol Screening and Brief Intervention (ASBI) program. ASBI is a targeted prevention program incorporating alcohol screening, brief feedback, and motivational interviewing to assist

patients in connecting their drinking behavior with their current injury or medical problem. Refer to the ALCOHOL SCREENING and BRIEF INTERVENTION (ASBI) PROGRAM IMPLEMENTATION and OPERATIONS MANUAL from the IHS Office of Clinical and Preventive Services, which can be found at:

<http://www.ihs.gov/NonMedicalPrograms/NC4/index.cfm?module=asbi>

OUTCOME: The patient/family will understand the connection between hazardous or harmful alcohol or other drug use and physical injury, medical problems and/or emotional and social distress.

STANDARDS:

1. Raise the subject: Ask permission to discuss the subject of alcohol, which lets the patient know that the wishes and perceptions of the patient are central to the treatment.
2. Provide feedback:
 - a. Discuss the results of alcohol screening, comparing quantity and frequency reported by the patient to non-hazardous drinking norms. The National Institute of Alcohol Abuse and Alcoholism offers specific guidelines for men and women regarding the maximal thresholds for low-risk drinking:
 - i. A standard drink is 12 oz. of beer, 1.5 oz. spirits, or 5 oz. of wine.
 - ii. Men should not drink more than fourteen drinks in any week and not more than four drinks in any given day.
 - iii. Women should not drink more than seven drinks in any week and not more than three drinks in any given day.
 - iv. People who drink below these levels may still be at risk for alcohol-related injuries, medical, and/or other alcohol-related problems. However, drinking above these amounts is known to place individuals at high risk.
 - b. Discuss the connection between the use of alcohol and the injury or adverse health consequences that resulted in the hospital or clinic visit. Explain the high risk of repeating the alcohol-injury event and killing or harming self or others as the events escalate.
3. Enhance motivation:
 - a. Have patient self-identify readiness to change.
 - b. Develop discrepancy between the patient's present behavior and the patient's own expressed concerns, which may tip the scales towards readiness to change.
 - c. Provide options that the patient can pursue to develop a plan for treatment of the underlying alcohol disorder and injury prevention as appropriate.
4. Negotiate and advise:

- a. Assist the patient to identify a goal from a menu of options.
- b. Explain to the patient that staying within agreed-upon limits will lessen the risk of experiencing further illness or injury related to alcohol use.
- c. Provide the patient with a drinking agreement.
- d. Explain the importance of follow-up.

AOD-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of alcohol and other drug abuse/dependence.

STANDARDS:

1. Review the potential short and long term effects that alcohol or other drugs have on the body, as appropriate:
 - a. tolerance and withdrawal symptoms, seizures, respiratory arrest, and death
 - b. GI disease, e.g., liver damage/cirrhosis, pancreatitis, ulcers, cancer
 - c. brain damage, dementia, neurological disorders
 - d. obesity, malnutrition, vitamin deficiencies
 - e. cardiac disease, e.g. cardiomyopathy, heart attack
 - f. ENT disorders, pulmonary disease
 - g. changes in thinking/personality, poor judgment, emotional disorders
 - h. behavior problems (loss of inhibitions, theft to support use, acting out of anger/irritability)
2. Discuss the stages of addiction and the progression of use, abuse, and dependence over time. Discuss withdrawal symptoms as a sign of dependence.
3. Review the potential adverse effects of alcohol and other drug abuse/dependence on the lifestyle of the individual, the family, and the community, which often results in:
 - a. loss of job
 - b. divorce or marital and family conflict, domestic violence
 - c. legal problems
 - d. consequences of unprotected sex, e.g., sexually transmitted infections, unplanned pregnancies
 - e. acute illness, exacerbation of chronic health problems
 - f. increased risk of injury or death to self or others, e.g., motor vehicle crashes, falls, assaults, homicide, or suicide

4. Discuss the common co-morbidity of alcohol and other drug abuse with mental health diagnoses, including depression, anxiety, and features of personality disorders.

AOD-CM CASE MANAGEMENT

OUTCOME: The patient/family will understand the importance of integrated case management in management of alcohol and other drug misuse.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family, and providers in the case management plan.
2. 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”](#).**
3. Discuss the concept of continuum of care in the treatment of alcohol and other drug use disorders including:
 - a. the pre-treatment, treatment, sobriety maintenance, follow-up, and relapse prevention phases
 - b. progression of care, where available, from inpatient settings to half-way houses, to intensive outpatient and outpatient settings for sober living
4. Provide assistance and advocacy to the patient/family in obtaining integrated services.

AOD-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

AOD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the disease process of alcohol and other drug 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 alcohol and other drug abuse/dependency.
2. Discuss the diagnosis of alcohol and other drug abuse/dependence and provide an opportunity to recognize the disease process/progression of abuse and dependence:
 - a. tolerance and withdrawal symptom
 - b. substance is taken in larger amounts or over a longer period than intended
 - c. persistent desire or unsuccessful efforts to cut down or control the substance use
 - d. a great deal of time spent in activities necessary to obtain the substance or recover from its effect
 - e. important social, occupational, or recreational activities are given up because of the substance use
 - f. substance use is continued despite knowledge of having a persistent or recurrent physical or psychological pattern likely caused or exacerbated by the substance

AOD-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity for a healthy and alcohol and other drug-free life style.

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.

AOD-FAS FETAL ALCOHOL SPECTRUM DISORDERS

OUTCOME: The patient/family will understand the importance of avoiding any consumption of alcohol during pregnancy.

STANDARDS:

1. Identify behaviors that reduce the risk for fetal alcohol syndrome.

2. Discuss that consumption of any amount of alcohol during pregnancy can cause FAS or FASD. Emphasize the importance of abstinence from any alcohol use during pregnancy (including beer, wine, liquor, and wine coolers).
3. 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
4. Assist the patient in developing a plan for prevention. Discuss available treatment or intervention options, as appropriate.

AOD-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of alcohol and other drugs.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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 (e.g., 12-step programs) and support services and refer as appropriate.

AOD-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from an alcohol/drug abuse help line or crisis intervention line.

STANDARDS:

1. Explain that a help line will enable the patient to talk with a specialist who can help in choosing a plan to assist in alcohol/drug use cessation which may include various types of treatment such as group or individual counseling and/or medications. Explain that a crisis intervention help line may assist in dealing with an immediate crisis.
2. Provide the help/quit/crisis intervention line phone number and hours of operation or assist in calling the line during the encounter.
3. Explain how the help/quit/crisis line works and what the patient can expect from calling and/or participating in the services.

AOD-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of alcohol and other drugs.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

AOD-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high-risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

AOD-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to alcohol and other drugs.

STANDARDS:

1. Discuss the importance of hand-washing in infection control, especially in relationship to food preparation/consumption, child care, and toilet use.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the damaging effects of alcohol and other drugs to tooth enamel. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing to blood-borne pathogens and sexually transmitted infections from unplanned, unprotected intercourse and/or use of contaminated needles and/or syringes.

AOD-INJ INJURIES

OUTCOME: The patient/family will receive understand the connection between alcohol or drug use and physical injury.

STANDARDS:

1. Discuss results of alcohol screening, comparing quantity and frequency to non-hazardous drinking.
2. Discuss the connection between the use of alcohol and the injury or adverse health consequence(s) that resulted in the hospital or clinic visit. **Refer to [“AOD-BNI Brief Negotiated Intervention”](#).**
3. Provide options that the patient can pursue to develop a plan for treatment of the underlying alcohol and other drug abuse disorder and injury prevention as appropriate

AOD-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 (e.g., 12-step programs).

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 alcohol and other drug issues.
2. Discuss the content of the literature.

AOD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations needed for recovery from alcohol and other drug dependence.

STANDARDS:

1. Discuss lifestyle adaptations specific to recovery from alcohol and other drug dependence:
 - a. minimizing exposure to alcohol and other drugs, such as avoiding bars and breweries
 - b. developing new and enjoyable alcohol and other drug-free activities/hobbies
 - c. attending alcohol and other drug-free social functions and community/family activities
 - d. making new friends who are alcohol and other drug-free or actively engaged in recovery
2. Discuss that the family may also require lifestyle adaptations to care for the patient, including reducing enabling behaviors and avoiding social drinking in the presence of the recovering individual.
3. Discuss ways to optimize quality of life, such as exploring or deepening spirituality.
4. Refer to community services (e.g., 12-step programs), resources, or support groups (e.g., Al-Anon, Alateen programs), as available.

AOD-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. This includes OTC medicines that may contain alcohol, e.g., cough syrup.
4. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Emphasize the importance of taking medications as prescribed, e.g., avoiding overuse, under use, or misuse
5. Discuss the importance of keeping a list of all current prescriptions and OTC medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

AOD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for treatment or management of an alcohol and other drug-free lifestyle.

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. Discuss strategies for managing food cravings, and the risks of rapid weight fluctuation.
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 role of nutrition in alcohol and other drug abuse.

STANDARDS:

1. Discuss strategies for managing food cravings, and the risks of rapid weight fluctuation.
2. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
3. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
4. Discuss the importance of regular meals and adequate fluid intake.
5. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
6. Refer to a registered dietitian for MNT.

AOD-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce the risk of developing alcohol and other drug-use disorders.

STANDARDS:

1. Emphasize awareness of risk factors associated with alcohol and other drug abuse and dependence, such as experimentation with alcohol and other drugs, binge drinking, and family history of alcohol and other drug abuse and dependence.
2. Discuss that the individual who is becoming dependent is often unaware of the progressive loss of control.
3. Discuss the impact of comorbid conditions and psychosocial stressors on alcohol and other drug abuse and dependence.
4. Discuss how alcohol and other drug abuse and dependence adversely affects the patient, the family, and the community.

AOD-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing:
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs

- e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications
 3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
 4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
 5. Refer for medical and psychosocial support services for any risk factor identified.

AOD-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of alcohol and other drugs abuse.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

AOD-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to alcohol and other drug use.

STANDARDS:

1. Discuss behavior changes (e.g., risk-taking) that can occur while someone is under the influence of alcohol or drugs and how these behaviors can put self and others in danger.
2. Discuss how rules and laws protect us (e.g., requirements for seatbelt and helmet use).
3. Emphasize the importance of a designated driver.
4. Discuss with the patient/family the following safety items as appropriate:
 - a. Discuss legal implications of putting others at risk. Involvement of a minor may be considered child abuse/neglect.
 - a. Discourage riding in a vehicle with anyone under the influence of alcohol or other drugs.
 - b. Explain ways to resist peer pressure and teach responsible ways friends can protect each other.
 - c. Discuss how to talk to parents and other adults about alcohol or drugs. Discuss feelings of guilt or responsibility.
 - d. Discuss information sources (e.g., school programs) and how to make informed decisions.

AOD-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in the treatment of alcohol and other drug 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 alcohol and other drug-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. exercising regularly
 - 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.

AOD-TX TREATMENT

OUTCOME: The patient/family will understand that alcohol and other drug abuse/dependence is a chronic disease which may be treated, but which usually includes a long-term process for maintaining sobriety/recovery.

STANDARDS:

1. Discuss the need to identify the patient's perceptions that promote alcohol and other drug abuse/dependence and to learn the mechanisms to modify those perceptions and associated behaviors.
 - a. Explain the importance of identifying the triggers that lead to use, and finding alternative activities and coping strategies to avoid use when exposed to those triggers.
 - b. Discuss relapse risk of alcohol and other drug abuse/dependence, and the need to utilize family, cultural/spiritual, and community resources to prevent relapse.
 - c. Discuss changes in lifestyle necessary to maintain sobriety, including new activities/hobbies, social functions, and friends.
2. Discuss the purpose for and the concerns/fears regarding placement at both inpatient and outpatient alcohol and other drug treatment facilities:
 - a. Explain the rationale for the recommended placement based on patient/family preference, level of need, court order, safety, eligibility, availability, and funding.
 - b. Explain that the purpose of inpatient placement is to ensure a safe and supportive environment for recovery from alcohol and other drug dependence.
 - c. Discuss alternative placement or treatment options if recommended placement is declined or unavailable.
 - d. Discuss the placement process, including the need for physical exams, the funding requirements, and the timelines for rehabilitation.

3. Explain that patients with dual diagnoses will require specialized treatment or adjunct mental health treatment.
4. Explain the stages of change as applied to the progression of alcohol and other drug abuse/dependence, e.g., pre-contemplation, contemplation, preparation, action, and maintenance.

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 understand the importance of follow-up in the treatment of allergies.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

AL-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding Allergies.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding Allergies and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

AL-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.

AL-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 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

AL-MNT MEDICAL NUTRITION THERAPY

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

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 known, the patient/family can use the elimination diet to discover what is causing the reaction.
2. Encourage the patient/family to keep a food diary to record reactions.
3. Emphasize the importance of reading all food labels. Instruct the patient/family as necessary.
4. Refer to a dietitian for assessment of nutritional needs and for appropriate treatment as indicated.

AL-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):

- a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
- a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

ALZ - Alzheimer's Disease

ALZ-ADL ACTIVITIES OF DAILY LIVING

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

STANDARDS:

1. Discuss the importance of supervising the patient's 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), or learning to assume responsibility of ADLs on behalf of the patient.
2. Assist the 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.

ALZ-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 many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is unable to provide guidance at the time that decisions need to be made.
3. Explain that Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences for care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer,) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.

6. Refer to [“ADV - Advance Directives”](#).

ALZ-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

ALZ-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to Alzheimer's disease.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with Alzheimer's disease as a life-altering illness that requires a change in lifestyle (refer to [“ALZ-LA Lifestyle Adaptations”](#)).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with Alzheimer's disease, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. Refer to [“AOD - Alcohol and Other Drugs”](#).
6. Refer to a mental health agency or provider.

ALZ-C COMPLICATIONS

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

STANDARDS:

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

3. Explain that patients may often develop comorbid conditions, such as depression (refer to [“DEP - Depressive Disorders”](#)), delirium (refer to [“DEL - Delirium”](#)), suicidal behavior (refer to [“SI - Suicidal Ideation and Gestures”](#)), psychosis, or aggressive behavior.
4. Explain that patients typically demonstrate disinhibited behavior, including disregard for social conventions, such as inappropriate jokes, undue familiarity with strangers, and neglecting personal hygiene.
5. Explain that patients have poor judgment and insight, leading to underestimation of risks involved in activities, which may result in injuries or deaths.
6. Explain that individuals with dementia are at risk for malnutrition, falls, and physical debility.

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”](#).

ALZ-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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 essential features of Alzheimer's disease involving the development of multiple cognitive deficits that include both:
 - a. Memory impairment (impaired ability to learn new information or to recall previously learned information)
 - b. One or more of the following cognitive disturbances:
 - i. Aphasia (language disturbance)
 - ii. Apraxia (impaired ability to carry out motor activities despite intact motor function)
 - iii. Agnosia (failure to recognize or identify objects or faces despite intact sensory function)
 - iv. Disturbance in executive functioning (i.e., planning, organization, sequencing, abstracting, reasoning)
4. 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
5. Explain that the cause is unknown and nothing can be done to prevent the disease. Encourage a healthy lifestyle and habits that prevent dementia (limit alcohol intake, stop smoking, eat well, exercise).
 6. Discuss the importance of maintaining a positive mental attitude.

ALZ-FU FOLLOW-UP

OUTCOME: The patient/family 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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding Alzheimer's Disease.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding Alzheimer's Disease and dealing with issues.
2. Provide the help line phone number or Internet address (URL), such as:
<http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001767/>

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 in 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.
 - h. Encourage the patient to exercise the mind by reading, puzzles, writing, etc. as appropriate. Avoid challenging to the point of frustration.
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. Explain the importance of supervising the patient during bathing and eating. Discourage leaving the patient alone for extended periods. **Refer to ["ALZ-S Safety"](#).**
5. Explain that over the course of the disease, home management will require frequent adjustments.
6. Encourage assistance with activities of daily living as appropriate. 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 that may limit or restrict activities.

ALZ-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.

3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

ALZ-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to Alzheimer's disease and the patient's decline in ability to tend to own hygiene.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

ALZ-L LITERATURE

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

STANDARDS:

1. Provide the 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-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

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. Explain the importance of serving high calorie foods first. Offer favorite foods. Discourage force feeding the patient.
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. Encourage walking or light exercise to stimulate appetite.
6. 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 dietitian 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

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

STANDARDS:

1. 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.
2. Discuss possible dangers as appropriate:
 - a. the current/potential abuse of alcohol or drugs.
 - b. the need to secure medications and other potentially hazardous items.
 - c. fire hazards such as cooking, smoking in bed, or smoking unsupervised.
 - d. patients may wander; alarms on doors, windows, and beds may be necessary
3. Discuss whether or not driving is safe.
4. Review the local resources and phone numbers, including the police that may be utilized during a crisis, and may assist in transportation and safety compliance.
5. Review the local resources and phone numbers, including the police that may be utilized during a crises, and may assist in transportation and safety compliance.
6. Discuss/review the safety plan with the family, including emergency procedures, should the condition worsen, if suicidal or homicidal ideation arises, or if aggressive or dangerous behavior arises.

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 and positive imagery
 - i. Participating in spiritual and cultural activities
 - j. Utilizing support groups
 - k. Utilizing respite care
4. Provide referrals as appropriate.

ALZ-TE TESTS

OUTCOME: The patient/family/caregiver will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results

- b. follow-up tests may be ordered based on the results
- c. how results will impact or effect the treatment plan
- d. recommendations based on the test results

ALZ-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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.).

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. 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.
3. 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.
4. Explain that an appropriate drug regimen can sooth agitation, anxiety, depression, and sleeplessness and may help boost participation in daily activities.
5. 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).
6. Refer to ["EOL - End of Life"](#).

AMP - Amputations

AMP-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

AMP-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to amputations.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of amputations and requires a change in lifestyle (**refer to ["AMP-LA Lifestyle Adaptations"](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common with amputations, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with amputations, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
4. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
5. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
6. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to ["AOD - Alcohol and Other Drugs"](#)**.
7. Refer to a mental health agency or provider.

AMP-C COMPLICATIONS

OUTCOME: The patient/family will understand common complications of amputations and their management.

STANDARDS:

1. Review the common physical complications associated with amputations, e.g., thromboembolism, pain/flexion contracture, increased mortality rate, trauma to residual limb, and ischemia in residual limb.
2. Review the common psychological complications associated with amputations, e.g., grieving, ineffective coping leading to mood and anxiety disorders.

AMP-CM CASE MANAGEMENT

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

STANDARDS:

1. Discuss 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”](#).**

AMP-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

AMP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of conditions associated with amputations.

STANDARDS:

1. Review disease process associated with amputations.
2. Review the physical limitations that may be imposed by amputations.

AMP-EQ EQUIPMENT

OUTCOME: The patient/family 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.

AMP-EX EXERCISE

OUTCOME: The patient/family will understand the role physical activity, based on the amputation, for optimal health.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Explain some of the benefits of exercise, including:
 - a. Preventing joint stiffness
 - b. Increasing muscle strength around the joints
 - c. Improving joint alignment and flexibility
 - d. Reducing pain
 - e. Maintaining strong and healthy bone and cartilage tissue
 - f. Helping to achieve or maintain a healthy weight
 - g. Improving overall emotional and physical fitness
3. Refer to a physical therapist or community resource, as appropriate.

AMP-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.

2. Discuss the procedure and process for obtaining follow-up appointments.
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.

AMP-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

AMP-L LITERATURE

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

STANDARDS:

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

AMP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle changes necessary to optimize performance of everyday activities.

STANDARDS:

1. Discuss that treatment for amputees usually involves a combination of rest and relaxation, exercise, proper diet, medication, joint protection, and ways to conserve energy. Discuss the ways to pain management. Refer to [“AMP-PM Pain Management”](#) and [“AMP-HPDP Health Promotion, Disease Prevention”](#).
2. Discuss Activity of Daily Living (ADL) aids. Make a referral to social services for assistance in procuring such devices.
3. Explain how exercise and social involvement may decrease the depression and anger often associated with amputations.
4. Discuss how self-image, pain, fatigue, inflammation, limited joint mobility, and medications can alter sexual desire and activity.
5. Assess the level of acceptance and offer support and referral to social services and community resources as appropriate.
6. Discuss the importance of relaxation to minimize stress, thus minimizing symptoms.

AMP-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 full participation with the medication plan and that this is the patient’s responsibility. Discuss any barriers to full participation.
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.

AMP-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 the amputation.

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.

AMP-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to amputations.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

AMP-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient and may be multifaceted. **Refer to ["PM - Pain Management"](#).**
3. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.

4. Explain non-pharmacologic measures that may be helpful with pain control.

AMP-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family 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 remove throw rugs, install safety bars in hallways and near stairs, hand rails and safety bars in bathrooms.
3. Stress the importance and proper use of mobility devices (cane, walker, electric scooters, and wheel chair).
4. Stress the proper use and care of prosthetic devices and affected limb(s).
5. Explain the importance of recognizing driving limitations. Refer to the community resources.

AMP-SM STRESS MANAGEMENT

OUTCOME: The amputee/family/caregiver will understand the role of stress management.

STANDARDS:

1. Explain that uncontrolled stress is linked with permanent disability that can impact an amputee's self-image, self-care, mobility, and can interfere with rehabilitation.
2. Explain that effective stress management can 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 from an amputation.
4. Explain that stress may cause inappropriate eating which can increase the likelihood of a sedentary lifestyle increasing the risk of disease related complications, e.g. cardiovascular disease, hypertension, and diabetes.
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 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
6. Provide referrals as appropriate.

AMP-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

AMP-TX TREATMENT

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

STANDARDS:

1. Discuss therapies that may be utilized. Emphasize the importance of active participation by the patient/family in the development of and participation with treatment plan.
2. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment, non-treatment, or failure to follow the treatment plan.
3. Discuss the importance of maintaining a positive mental attitude.
4. Refer to the Amputee Coalition of America or community resources as appropriate.

AN - Anemia

AN-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of red blood cells as they relate to anemia.
2. Discuss the changes to anatomy and physiology as a result of anemia.
3. Discuss the impact of these changes on the patient's health or well-being.

AN-C COMPLICATIONS

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

STANDARDS:

1. Explain that untreated anemia will result in a chronic lack of oxygen, producing signs and symptoms such as:
 - a. chronic or severe fatigue
 - b. chronic dyspnea
 - c. inability to concentrate
 - d. irritability
 - e. depression
 - f. anxiety
 - g. tachycardia
 - h. susceptibility to infection.
2. In children anemia may result in impaired brain growth/development.
3. 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.

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 organs 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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/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. 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.
2. Explain that 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.
3. 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.
4. 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. Discuss the indications, risks, and 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site

- d. Time out for patient identification and procedure review
- e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

AN-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

AN-TX TREATMENT

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

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 appointments.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

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 will 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 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 and the patient; and may be multifaceted. Refer to [“PM - Pain Management.”](#)
3. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. 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, intrathecal, and regional blocks) and how it relates to effective anesthesia.
2. Explain the specific procedure(s) to be performed, including the risks and benefits of performing the procedure, as well as, the risks and benefits of refusing the procedure.
3. Discuss alternatives to the proposed procedure(s), including expectant management, as appropriate.
4. Discuss the expected patient/family involvement in the care required following the proposed procedure(s).
5. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
6. Discuss pain management as appropriate.

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.

ABXD - Antibiotic Associated Diarrhea

(includes *C. difficile*)

ABXD-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of the colon and its normal flora.
2. Discuss the changes to anatomy and physiology related to antibiotic associated diarrhea.
3. Discuss the impact of these changes on the patient's health or well-being.

ABXD-C COMPLICATIONS

OUTCOME: The patient/family will understand complications of antibiotic associated diarrhea.

STANDARDS:

1. Discuss common complications of antibiotic associated diarrhea (e.g., prolonged diarrhea, perianal skin excoriation, pseudomembranous colitis, and dehydration).
2. Describe the signs/symptoms of common complications of antibiotic associated diarrhea (e.g. severe diarrhea, abdominal pain, and fever).
3. Explain that use of over-the-counter anti-diarrheals may increase bacterial/toxin exposure and lead to more tissue damage in the colon.

ABXD-CM CASE MANAGEMENT

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

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”](#).**

ABXD-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

ABXD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand antibiotic associated diarrhea.

STANDARDS:

1. Discuss that antibiotic associated diarrhea results from a disruption in the balance of normal intestinal flora. This provides the ideal environment for bacteria to multiply and/or secrete toxins. This can happen as a result of broad-spectrum antibiotic therapy. Other causes of bacterial disruption may include gastrointestinal surgery, chemotherapy or other immunosuppression.
2. Explain that symptoms may include frequent loose stools, abdominal pain and cramps, nausea, fever, dehydration, fatigue and leukocytosis.
3. Explain that the risk of being affected increases with age, hospitalization or residence at a nursing home.
4. Explain that antibiotic associated diarrhea may be transmitted to others. Hand hygiene may help reduce this risk. (Refer to [“ABXD-HY Hygiene”](#).)

ABXD-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment

- e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
 - g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
 3. 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.

ABXD-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

ABXD-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to antibiotic associated diarrhea.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

ABXD-ISO ISOLATION

OUTCOME: The patient/family will understand the reasons and procedures for isolation of the patient in preventing and controlling the spread of antibiotic associated diarrhea.

STANDARDS:

1. Explain that isolation of the patient prevents the spread of antibiotic associated diarrhea to healthcare providers, other patients, and family members.
2. Describe the type of isolation being implemented and associated precautions and protective equipment to be used.

ABXD-L LITERATURE

OUTCOME: The patient/family will receive literature about antibiotic associated diarrhea.

STANDARDS:

1. Provide the patient/family with literature on antibiotic associated diarrhea.
2. Discuss the content of the literature.

ABXD-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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. Explain that use of over the counter anti-diarrheals may increase bacterial/toxin exposure and lead to more tissue damage in the colon.

ABXD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for antibiotic associated diarrhea.

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.

ABXD-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to antibiotic associated diarrhea.

STANDARDS:

1. Discuss the importance of adequate fluid intake.
2. Discuss what foods may be better tolerated during times of illness such as BRAT diet (bananas, rice, applesauce and toast).
3. Refer to a registered dietitian, as appropriate.

ABXD-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of developing antibiotic associated diarrhea.

STANDARDS:

1. Discuss that most cases of antibiotic associated diarrhea occur in people who have been taking broad spectrum antibiotics. Appropriate use of antibiotics can help lessen the incidence.
2. Explain there may be a role in taking pro-biotics in preventing antibiotic associated diarrhea.

3. Explain that it is possible to be a carrier of the bacteria that causes antibiotic associated diarrhea without having symptoms. Thorough hand hygiene following handling of all human waste can help minimize transmission to others.

ABXD-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Time out for patient identification and procedure review
5. Discuss pain management as appropriate.

ABXD-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results

- c. how results will impact or effect the treatment plan
- d. recommendations based on the test results

ABXD-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 participation with treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Explain that use of over the counter anti-diarrheals may increase bacterial/toxin exposure and lead to more tissue damage in the colon.

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. Explain why antibiotics are only effective in treating bacterial infections.
2. Discuss the potential to create resistant bacteria every time an antibiotic is used.
3. 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
4. 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. 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
5. 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 develop ways to survive antibiotics that were meant to kill them.
2. Discuss how antibiotic resistance may develop:
 - a. Antibiotic resistance can occur by the bacteria developing a way to block the antibiotic, deactivate the antibiotic, or pump the antibiotic out of the bacteria.
 - b. Antibiotic resistance occurs from exposure to an antibiotic when:
 - i. Antibiotics are given to patients for viral infections.
 - ii. The antibiotic is not taken for the full duration of treatment.
 - iii. Skipping doses results in the bacteria being exposed to sub-therapeutic concentrations, allowing for the bacteria to survive and for resistance to occur
 - iv. Food-producing animals are given antibiotic drugs for therapeutic reasons, disease prevention, or production reasons. These drugs have the downside of potentially causing microbes to become resistant to drugs used to treat human illness.
3. Discuss illnesses which are commonly caused by viruses and do not require antibiotics.

ABX-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up if symptoms do not resolve.

STANDARDS:

1. Encourage the patient to seek follow-up 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 as soon as expected.

ABX-L LITERATURE

OUTCOME: The patient/family will receive literature about antibiotic resistance.

STANDARDS:

1. Provide the patient/family with literature on antibiotic resistance.
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.

ACC - Anticoagulation

ACC-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to the condition being treated.

STANDARDS:

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

ACC-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of anticoagulation therapy and/or the 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 not be completely controllable.
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: The patient/family will understand anticoagulation therapy.

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.
 - a. what causes a blood clot
 - b. the risks of developing blood clots
 - c. the methods to prevent the formation of blood clots

4. Discuss the signs and symptoms of active clotting or over-anticoagulation.

ACC-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

ACC-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of anticoagulation.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

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 for anticoagulation therapy.

STANDARDS:

1. Emphasize the importance of avoiding activities that increase the risk of trauma or bleeding while receiving anticoagulation therapy.

2. Review the areas that may require adaptations, e.g., diet and physical activity.

ACC-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

ACC-MNT MEDICAL NUTRITION THERAPY

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

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 anticoagulation therapy.

STANDARDS:

1. Explain the importance of a consistent diet while receiving anticoagulation therapy.
2. Explain how foods high in vitamin K and omega 3 fatty acids may alter the anticoagulation therapy.
3. Discuss that herbs and supplements, including vitamin E and omega 3 fatty acids, may interfere with anticoagulants. Consult with a provider before using any of these products.
4. Refer to a registered dietitian, as appropriate.

AOD-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing:
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status

- b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

ACC-S SAFETY

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 bleeding, clot, or trauma.
3. Discuss the importance of informing all healthcare workers of anticoagulation therapy.
4. Emphasize the importance of avoiding activities that increase the risk of trauma or bleeding while receiving anticoagulation therapy.
5. Discuss the use of medical alert identifiers.

ACC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results

- b. follow-up tests may be ordered based on the results
- c. how results will impact or effect the treatment plan
- d. recommendations based on the test results

ASLT - Assault, Sexual

ASLT-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

ASLT-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to sexual assault.

STANDARDS:

1. Discuss the common difficulty in coping with the impact of sexual assault.
2. Discuss the potential stress, anger, sadness, fear, or other emotional reactions that are common in sexual assault, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the condition, and the importance of seeking help in accepting and coping with sexual assault.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to ["AOD - Alcohol and Other Drugs"](#).**
6. Refer to a mental health agency or provider, as needed.

ASLT-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications that can result from sexual assault.

STANDARDS:

1. Discuss the most common complications which may include flashbacks, shock and disbelief, shame, self-blame, anger, isolation and loss of control.
2. Discuss the possibility that many patients develop acute or chronic psychological disorders, eating disorders, and suicidality as well as nonspecific somatic complaints including headaches, abdominal pain, and sleep disturbances.

3. Discuss the physical complications secondary to the assault.
4. Discuss the possibilities of infection and pregnancy and medications that can help prevent these complications

ASLT-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of adequate and early psychological follow-up.
2. Discuss medical follow-up.
3. Inform patients about legal follow up provided by law enforcement and advocate consultation.
4. Provide a list of any private and public community agencies that can provide or arrange for assessment and care of individuals involved in sexual assault.

ASLT-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding sexual assault.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding sexual assault and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

ASLT-IR INFORMATION AND REFERRAL

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

STANDARDS:

1. Discuss alternative or additional sources for care and services, including a list of any private and public community agencies that can provide or arrange for assessment and care of individuals involved in sexual assault.
2. Provide patient/family with assistance in securing alternative or additional resources as needed.

ASLT-L LITERATURE

OUTCOME: The patient/family will receive literature about sexual assault.

STANDARDS:

1. Provide the patient/family with literature on sexual assault, including a list of any private and public community agencies that can provide assessment and care.
2. Discuss the content of the literature.

ASLT-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
5. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.

ASLT-P PREVENTION

OUTCOME: The patient will understand behaviors that reduce the risk of sexual assault.

STANDARDS:

1. Discuss information about sexual assault, appropriate consent for sexual relationships, and importance of a safe environment.
2. Discuss behaviors or situations that can decrease the chances of being sexually assaulted, e.g., avoidance of alcohol and drugs, use of a "buddy system."

ASLT-PRO PROCEDURES

OUTCOME: The patient/family will understand the procedures and examinations for sexual assault.

STANDARDS:

1. Explain the process of forensic examination and what to expect.
2. Explain the different parts of the examination (e.g., oral, anogenital, entire body) for signs of trauma, evidence collection, and serologic testing.

3. Discuss that clothing may be collected as part of the examination and may not be returned to the patient.
4. Discuss post-procedure management, mandatory reporting requirements, and follow-up.

ASLT-RI PATIENT RIGHTS AND RESPONSIBILITIES

OUTCOME: The patient/family will understand personal rights associated with sexual assault.

STANDARDS:

1. Explain the right to decline any portion of the exam and the ability to stop the exam at any point.
2. Encourage communication about any discomfort or questions to the examiner and to ask for a break from the exam if needed.
3. Offer the opportunity to have a family member, friend, or patient advocate in the room during all parts of the examination.

ASLT-RP MANDATORY REPORTING

OUTCOME: The patient/family will understand the process of mandatory reporting.

STANDARDS:

1. Emphasize importance of reporting suspected sexual assault to the proper law enforcement and child welfare/protective agencies and the patient's healthcare provider.
2. Explain that mandatory reporting is necessary to ensure the safety of all victims.
3. Explain that requirements for mandatory reporting vary by state. Some states require reporting for "reasonable cause to believe" while others require reported for "known or suspected" sexual assault.
4. Explain that states may require healthcare providers, mental healthcare providers, teachers, social workers, day care providers, and law enforcement personnel to report suspected sexual assault.
5. Explain that failure to report such information may result in criminal or civil liability for the provider.

ASLT-S SAFETY

OUTCOME: The patient/family will understand the safety issues as they relate to sexual assault.

STANDARDS:

1. Be sure victims and family members are aware of shelters and other support options available in their area. Offer a list of resources and make referrals as appropriate.
2. Assist to develop a plan of action that will ensure safety of all people in the environment of violence.

ASLT-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

ASLT-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options for sexual assault.

STANDARDS:

1. Explain the treatment options including:
 - a. the use of antibiotics, antivirals, vaccination and postcoital contraception in the prevention of complications. **Refer to [“FP-EC Emergency Contraception \(Post-coital\)”](#).**
 - b. the importance of timely psychological and medical treatment.
2. Discuss referral to community resources as appropriate

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”](#).**

ASM-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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](#), [“ASM-PF Peak-Flow Meter](#), [“ASM-MDI Metered-Dose Inhalers](#), and [“ASM-SPA Spacers](#) 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding asthma.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding asthma and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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/remove 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 the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
5. 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.”](#)**

ASM-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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 sulfates (red wine, sausages, salad bars).
2. Refer to a registered dietitian 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/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Explain that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, and many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness when exposed to cigarette smoke either directly or via second-hand/third-hand smoke.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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-OT Quit.”](#)**

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-SMP SELF MANAGEMENT PLAN

OUTCOME: The patient/family will understand the importance of an asthma self management plan.

STANDARDS:

1. Explain that an asthma management plan helps to treat asthma symptoms promptly when used in combination with routine peak flow monitoring.
2. Explain that an asthma management plan provides the patient/family with instructions on how to manage asthma based upon peak flow meter results and symptoms.
 - a. Green Zone (80-100% personal best peak flow): represents times when the patient is breathing well, not coughing or wheezing, and can work/play normally. Instruct the patient to continue the current treatment plan.
 - b. Yellow Zone (50-80% personal best peak flow): represents times when the patient is coughing or wheezing, having difficulty breathing, or is waking up at night from asthma symptoms. Patients should receive instructions on appropriate therapy.
 - c. Red Zone (< 50% peak flow): represents times when the patient is breathing hard and fast, cannot talk/walk well, and is not receiving relief from the current treatment plan. Patients should receive instructions on appropriate therapy and advice to seek medical attention immediately.
3. Provide the patient/family with a copy and discuss the appropriate use of the asthma management plan.

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, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

ASM-TO TOBACCO (SMOKING)

OUTCOME: The patient/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](#).**

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.

ADHD - Attention-Deficit/Hyperactivity Disorder

ADHD-C COMPLICATIONS

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

STANDARDS:

1. Discuss that ADHD is part of a spectrum of, and may co-exist with other psychiatric diagnoses, including Oppositional Defiant Disorder and Conduct Disorder.
2. Discuss that dysfunctional family dynamics often exists in the homes of persons with ADHD, and that usual disciplinary measures are often not effective with children with ADHD.
3. Discuss that growth delay is often a problem with treated and untreated ADHD and may require intervention by a registered dietitian. **Refer to [“ADHD-N Nutrition](#).**
4. Discuss that persons with ADHD are at increased risk of injuries.
5. Discuss that persons with ADHD often have problems with learning and behavior at school and other organized activities.

ADHD-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, school personnel/teachers, 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](#).**

ADHD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the nature and course of ADHD.

STANDARDS:

1. Discuss the pattern of symptoms present in ADHD, some of which must have been present before the age of 7, but may be diagnosed in adulthood:
 - a. Inattention
 - i. Makes careless mistakes or fails to pay close attention.
 - ii. Has difficulty sustaining attention.
 - iii. Appears not to listen.
 - iv. Does not follow through on instruction, or fails to complete tasks.
 - v. Often loses things.
 - vi. Is forgetful.
 - b. Hyperactivity
 - i. Fidgets with hands and feet, or squirms in seat.
 - ii. Leaves seat when remaining in seat is expected.
 - iii. Often runs about or climbs excessively when its inappropriate.
Restlessness in adults and adolescents.
 - iv. Has difficulty playing or engaging in leisure activities quietly.
 - v. Talks excessively.
 - c. Impulsivity
 - i. Blurts out answers before questions have been completed.
 - ii. Has difficulty awaiting turn.
 - iii. Often interrupts or intrudes on others.
 - d. Associated Features
 - i. Has low frustration tolerance, temper outbursts, bossiness, stubbornness, mood lability, demoralization, dysphoria, rejection by peers and teachers, and poor self-esteem.
2. Discuss that the persistent pattern of inattention and/or hyperactivity/impulsivity is due to a central nervous dysfunction, and must be present in more than one area of functioning (e.g., home, school, and work).
3. Explain that ADHD is categorized into three subtypes: Predominantly Inattentive Type, Predominantly Hyperactive- Impulsive Type, and Combined Type.
4. Discuss the current theories of the causes of ADHD:
 - a. Neurological: Central Nervous System Dysfunction
 - b. Environmental toxins: lead, prenatal exposure to cigarette smoke and alcohol
 - c. Genetics

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- d. Environmental Factors: Parenting and social variables
5. Discuss the problems associated with ADHD: impaired academic achievement, learning disabilities, health problems, social problems, family conflicts, oppositional behavior, and sleep problems.
6. Discuss the prognosis for ADHD; most people with ADHD learn to compensate for their deficiencies and no longer need medication into adulthood.

ADHD-FU FOLLOW-UP

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

STANDARDS:

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

ADHD-GD GROWTH AND DEVELOPMENT

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

STANDARDS:

1. Refer to [“ADHD-N Nutrition](#).

ADHD-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding ADHD.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding ADHD and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

PATIENT EDUCATION PROTOCOLS:**ATTENTION-DEFICIT/HYPERACTIVITY DISORDER**

ADHD-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, including behavioral health services.
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

ADHD-L LITERATURE

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

STANDARDS:

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

ADHD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will have an increased understanding of the factors that contribute to better outcomes for ADHD children and adults.

STANDARDS:

1. Explain that the treatment of ADHD 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 in all areas of functioning (including school and home) 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 ADHD 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.

ADHD-M MEDICATIONS

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

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

ADHD-MNT MEDICAL NUTRITION THERAPY

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

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.

PATIENT EDUCATION PROTOCOLS:**ATTENTION-DEFICIT/HYPERACTIVITY DISORDER**

ADHD-N NUTRITION

OUTCOME: The patient/family will understand nutritional requirements for the child with 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 ADHD suppress appetite. Timing of medication may need to be adjusted to optimize hunger at mealtimes.
3. Explain that children with ADHD are distractible and may need to be reminded to eat.
4. Discuss that academic performance and behavioral compliance may improve with opportunities for calorie intake in mid-morning and mid-afternoon.

ADHD-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of ADHD.

STANDARDS:

1. Review the reason for the initial referral for therapy as part of the care plan.
2. Emphasize that full participation and follow-up is critical to treatment success. Emphasize parental responsibility for children's attendance.
3. Emphasize the importance of openness and honesty with the therapist.
4. Discuss issues of safety, confidentiality, and responsibility.
5. Explain that the therapist and the patient/ parents will establish goals and duration of therapy together.

ADHD-TE TESTS

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

STANDARDS:

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

ADHD-TX TREATMENT

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

STANDARDS:

1. Discuss that the therapy for ADHD is multi-factorial and may consist of:
 - a. Parent Education
 - b. Behavior Management and Behavior Therapy (consistent in the school and home)
 - c. Educational Management
 - d. Play therapy/psychotherapy
 - e. Medication Therapy

ATO - Autoimmune Disorders

ATO-ADV **ADVANCE DIRECTIVE**

OUTCOME: The patient/family 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 many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is able to provide guidance at the time that decisions need to be made.
3. Explain that the Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences of care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.

ATO-AP **ANATOMY AND PHYSIOLOGY**

OUTCOME: The patient/family will understand anatomy and physiology as it relates to the immune system and organs affected by the autoimmune disorder.

STANDARDS:

1. Explain the normal anatomy and physiology of the immune system and other involved organs.
2. Discuss the changes to anatomy and physiology as a result of the autoimmune disorder.
3. Discuss the impact of these changes on the patient's health or well-being.

ATO-BH **BEHAVIORAL AND EMOTIONAL HEALTH**

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to ATO.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with ATO as a life-altering illness that requires a change in lifestyle (**refer to [“ATO-LA Lifestyle Adaptations](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with ATO, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#)**.
6. Refer to a mental health agency or provider.

ATO-C COMPLICATIONS

OUTCOME: The patient/family will understand how to lessen the complications of the patient’s particular autoimmune disorder.

STANDARDS:

1. Review the common complications associated with the autoimmune disorder.
2. Review the treatment plan with the patient/family. Explain that complications are worsened by non-participation with the treatment plan.

ATO-CM CASE MANAGEMENT

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

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](#)**.

ATO-DP DISEASE PROCESS

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

STANDARDS:

1. Discuss the causes and effects of the autoimmune disorder.
2. Describe autoimmune disorders as a spectrum of disorders caused by inappropriate activation of the immune system against the rest of the body.
3. Explain that diagnosis is difficult and treatments are highly individualized and may vary over the course of the particular autoimmune disorder.
4. Explain that outcome varies with the specific disorder. Most are chronic, but many can be controlled with treatment.
5. Explain that symptoms of the autoimmune disorders vary widely depending on the type of disorder. A group of non-specific symptoms often accompany the autoimmune disorder. Review these symptoms with the patient.:
 - a. tires 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

ATO-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding ATO.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding ATO and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

ATO-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of the particular autoimmune disorder.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.

ATO-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

ATO-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to the particular autoimmune disorder.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.

- a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
 3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
 4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
 5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

ATO-L LITERATURE

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

STANDARDS:

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

ATO-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

1. Discuss lifestyle adaptations specific to the autoimmune disorder, such as diet, physical activity, sexual activity, role changes, communication skills, and interpersonal relationships.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

ATO-MNT MEDICAL NUTRITION THERAPY

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

STANDARDS:

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

ATO-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age

- c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

ATO-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

ATO-PRO PROCEDURE

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 of 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 for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

ATO-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of the particular autoimmune disorder.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

ATO-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in the 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 quiet the inappropriately stimulated immune system, 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, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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 the 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-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family 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 many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is able to provide guidance at the time that decisions need to be made.
3. Explain that the Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences of care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.

BH-ANA ABUSE AND NEGLECT – ADULT (SEE ABUSE AND NEGLECT - [“ABNG - Abuse and Neglect \(child or elder\)”](#))

BH-ANC ABUSE AND NEGLECT – CHILD (SEE ABUSE AND NEGLECT - [“ABNG - Abuse and Neglect \(child or elder\)”](#))

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”](#).

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. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

BH-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to the condition or illness.

STANDARDS:

1. Discuss the common difficulty in coping with the diagnosis that may require a change in lifestyle.

2. Discuss the potential stress, anger, sadness, fear, or other emotional reactions that are common with the diagnosis, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).**
6. Refer to a mental health agency or provider.

BH-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

BH-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in health and wellness.

STANDARDS:

1. Discuss medical clearance issues for physical activity.

2. Discuss the benefits of any exercise, such as improvement in well being, stress and depression 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.

BH-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

BH-GP GRIEVING PROCESS

OUTCOME: The patient/family will understand the grieving process as it relates to the specific issue or problem.

STANDARDS:

1. Explore any feelings and losses that affect the patient and the patient's loved ones.
2. Discuss the importance of keeping open communication and promoting social interaction in preserving the dignity of the patient.
3. Explore how separation and mourning are aspects of the bereavement process.
4. Explain that the need to repeatedly verbalize feelings is a normal part of grieving.
5. Refer to ["GRIEF - Grief/Bereavement"](#).

BH-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding the condition or illness.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding the condition or illness and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

BH-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management skills and procedures.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

BH-HOU HOUSING

OUTCOME: The patient/family will understand the relationship between adequate and safe housing and optimal health.

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:
 - a. secure shelter or housing services.
 - b. secure utilities, e.g., running water, electricity.
 - c. understand the options available for emergency shelter and/or affordable housing.
3. Explain information pertaining to proper utilization of federal, state, county, and Tribal resources, e.g., home site leases, and archeological and aerial surveys.

BH-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.

2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

BH-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

BH-IB INSURANCE/BENEFITS

OUTCOME: The patient/family will understand the differences among various financial and insurance programs and benefits.

STANDARDS:

1. Explain the process for completing the applications for SSI, Social Security, or other needs assistance, e.g., TANF, food stamps, etc.
2. Provide assistance to patients/families in completing the appropriate applications for identifiable 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 the 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-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for the condition or illness.

STANDARDS:

1. Discuss lifestyle adaptations specific to the condition or illness.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

BH-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

BH-PA PARENTING

OUTCOME: The patient/family will understand the parenting skills appropriate to meeting the needs of the child(ren).

STANDARDS:

1. Discuss the methods for appropriate parenting at home, including the appropriate use of rewards and consequences, and methods for improving the adult-child relationship.
2. Discuss the physical, emotional, and cognitive needs of the child based on age and level of development.
3. Emphasize the importance communicating in a way that the child understands.
4. Discuss the methods for providing emotional support and unconditional assistance to the child.
5. Refer the family to mental health services/family counseling if the family/child(ren) are becoming overwhelmed.

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-PRO PROCEDURE

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 of 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 for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

BH-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of the patient's mental health condition.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.

6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

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 danger to harm self and others or inability to care for self, as appropriate.
3. Explain to the patient/family the process for addressing conflict resolution and grievance.

BH-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to condition or illness.

STANDARDS:

1. Discuss the safety plan/contract with the patient, including no-harm contract and local resources and phone numbers, in case the condition worsens.
2. Discuss the process of hospitalization should the patient have difficulties staying safe.
3. Explain that local police may also be available to assist in transportation and safety compliance.

BH-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in coping with the particular problem or issue.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in coping with the particular problem or issue.
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.

BH-TE TEST/SCREENING

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

BH-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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.

BELL - Bell's Palsy

BELL-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand 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, saline drops, or lubricant eye ointment in the eyes may be helpful.
3. Explain that the healthcare provider may recommend the use of tape or an eye patch to help close the eye.
4. Explain that the recovery for complete paralysis takes longer and that there is an increased incidence of residual symptoms. During the recovery period, regrowth of nerve fibers may result in tearing while eating and unexpected muscle contractions during voluntary facial movements.

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 facial weakness 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 and usually complete. Some of the symptoms may last longer and may never completely disappear.

BELL-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of regular follow-up in the treatment of Bell's Palsy.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

BELL-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding Bell's Palsy.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding Bell's Palsy and dealing with issues.
2. Provide the help line phone number or Internet address (URL), such as <http://www.ninds.nih.gov/disorders/bells/bells.htm>

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/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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

BELL-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient; and may be multifaceted. **Refer to ["PM - Pain Management"](#).**
3. Explain medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

BELL-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing

- b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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 that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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 setting.
 - 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}Tc Technetium and ⁶⁷Ga Gallium scans are also reasonably sensitive means for detecting sacroiliitis and other axial skeletal infections. Joint involvement in brucellosis may vary from pain to joint immobility and effusion. While the sacroiliac joints are most commonly involved, peripheral joints (notably, hips, knees, and ankles) may also be affected. Meningitis complicates a small minority of brucellosis cases, and encephalitis, peripheral neuropathy, radiculoneuropathy and meningovascular syndromes have also been observed in rare instances. Behavioral disturbances and psychoses appear to occur out of proportion to the height of fever, or to the amount of overt CNS disease. This raises questions about an ill-defined neurotoxic component of brucellosis.

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

unlikely to be present within 14 days after a BW aerosol attack. It is characterized by cutaneous and intramuscular abscesses on the legs and arms. These lesions are associated with enlargement and induration of the regional lymph channels and nodes. The chronic form may be asymptomatic, especially with melioidosis. There have been cases associated with the development of osteomyelitis, brain abscess, and meningitis.

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

present. Rarely, a cervical bubo might result from an inhalational exposure. The chest X-ray findings are variable, but most commonly reveal bilateral infiltrates, which may be patchy or consolidated. The pneumonia progresses rapidly, resulting in dyspnea, stridor, and cyanosis. The disease terminates with respiratory failure, and circulatory collapse. Nonspecific laboratory findings include a leukocytosis, with a total WBC count up to 20,000 cells with increased bands, and greater than 80 percent polymorphonuclear cells. One also often finds increased fibrin split products in the blood indicative of a low-grade DIC. The BUN, creatinine, ALT, AST, and bilirubin may also be elevated, consistent with multi-organ failure. In man, the mortality of untreated bubonic plague is approximately 60 percent (reduced to <5% with prompt effective therapy), whereas in untreated pneumonic plague the mortality rate is nearly 100 percent, and survival is unlikely if treatment is delayed beyond 18 hours of infection. In the U.S. in the past 50 years, 4 of the 7 pneumonic plague patients (57%) died. Recent data from the ongoing Madagascar epidemic, which began in 1989, corroborate that figure; the mortality associated with respiratory involvement was 57%, while that for bubonic plague was 15%.

- e. **Q-Fever:** Fever, cough, and pleuritic chest pain may occur as early as ten days after exposure. Patients are not generally critically ill, and the illness lasts from 2 days to 2 weeks. Following the usual incubation period of 2–14 days, Q fever generally occurs as a self-limiting febrile illness lasting 2 days to 2 weeks. The incubation period varies according to the numbers of organisms inhaled, with longer periods between exposure and illness with lower numbers of inhaled organisms (up to forty days in some cases). The disease generally presents as an acute non-differentiated febrile illness, with headaches, fatigue, and myalgias as prominent symptoms. Physical examination of the chest is usually normal. Pneumonia, manifested by an abnormal chest x-ray, occurs in half of all patients, but only around half of these, or 28 percent of patients, will have a cough (usually non-productive) or rales. Pleuritic chest pain occurs in about one-fourth of patients with Q fever pneumonia. Chest radiograph abnormalities, when present, are patchy infiltrates that may resemble viral or mycoplasma pneumonia. Rounded opacities and adenopathy have also been described. Approximately 33 percent of Q fever cases will develop acute hepatitis. This can present with fever and abnormal liver function tests with the absence of pulmonary signs and symptoms. Uncommon complications include chronic hepatitis, culture-negative endocarditis, aseptic meningitis, encephalitis and osteomyelitis. Most patients who develop endocarditis have pre-existing valvular heart disease.
- f. **Tularemia:** Ulceroglandular tularemia presents with a local ulcer and regional lymphadenopathy, fever, chills, headache and malaise. Typhoidal tularemia presents with fever, headache, malaise, substernal discomfort, prostration, weight loss and a non-productive cough. After an incubation period varying from 1–21 days (average 3–5 days), presumably dependent upon the dose of organisms, onset is usually acute. Tularemia typically appears in one of six forms in man depending upon the route of inoculation: typhoidal,

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

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

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

- h. **Venezuelan Equine Encephalitis:** Incubation period 1–6 days. Acute systemic febrile illness with encephalitis developing in a small percentage (4% children; < 1% adults). Generalized malaise, spiking fevers, rigors, severe headache, photophobia, and myalgias for 24–72 hours. Nausea, vomiting, cough, sore throat, and diarrhea may follow. Full recovery from malaise and fatigue takes 1–2 weeks. The incidence of CNS disease and associated morbidity and mortality would be much higher after a BW attack. Susceptibility is high (90-100%), and nearly 100% of those infected develop overt illnesses. The overall case fatality rate for VEE is <1%, although it is somewhat higher in the very young or aged. Recovery from an infection results in excellent short-term and long-term immunity. VEE is primarily an acute, incapacitating, febrile illness with encephalitis developing in only a small percentage of the infected population. Most VEE infections are mild (EEE and WEE are predominantly encephalitis infections). After an incubation period from 1–6 days, onset is usually sudden. The acute phase lasts 24–72 hours and is manifested by generalized malaise, chills, spiking high fevers (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. Kyasanur Forest disease and Omsk hemorrhagic fever are notable for pulmonary involvement, and a biphasic illness with subsequent CNS manifestations. Among the arenavirus infections, Lassa fever can cause severe peripheral edema due to capillary leak, but hemorrhage is uncommon, while hemorrhage is commonly caused by the South American arenaviruses. Severe hemorrhage and nosocomial transmission are typical for Congo-Crimean HF. Retinitis is commonly seen in

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

- j. **Botulinum:** Usually begins with cranial nerve palsies, including ptosis, blurred vision, diplopia, dry mouth and throat, dysphagia, and dysphonia. This is followed by symmetrical descending flaccid paralysis, with generalized weakness and progression to respiratory failure. Symptoms begin as early as 12–36 hours after inhalation, but may take several days after exposure to low doses of toxin. The onset of symptoms of inhalation botulism usually occurs from 12 to 36 hours following exposure, but can vary according to the amount of toxin absorbed, and could be reduced following a BW attack. Recent primate studies indicate that the signs and symptoms may not appear for several days when a low dose of the toxin is inhaled versus a shorter time period following ingestion of toxin or inhalation of higher doses. Cranial nerve palsies are prominent early, with eye symptoms such as blurred vision due to mydriasis, diplopia, ptosis, and photophobia, in addition to other cranial nerve signs such as dysarthria, dysphonia, and dysphagia. Flaccid skeletal muscle paralysis follows, in a symmetrical, descending, and progressive manner. Collapse of the upper airway may occur due to weakness of the oropharyngeal musculature. As the descending motor weakness involves the diaphragm and accessory muscles of respiration, respiratory failure may occur abruptly. Progression from onset of symptoms to respiratory failure has occurred in as little as 24 hours in cases of severe food borne botulism. The autonomic effects of botulism are manifested by typical anticholinergic signs and symptoms: dry mouth, ileus, constipation, and urinary retention. Nausea and vomiting may occur as nonspecific sequelae of an ileus. Dilated pupils (mydriasis) are seen in approximately 50 percent of cases. Sensory symptoms usually do not occur. Botulinum toxins do not cross the blood/brain barrier and do not cause CNS disease. However, the psychological sequelae of botulism may be severe and require specific intervention. Physical examination usually reveals an afebrile, alert, and oriented patient. Postural hypotension may be present. Mucous membranes may be dry and crusted and the patient may complain of dry mouth or sore throat. There may be difficulty with speaking and swallowing. Gag reflex may be absent. Pupils may be dilated and even fixed. Ptosis and

extraocular muscle palsies may also be present. Variable degrees of skeletal muscle weakness may be observed depending on the degree of progression in an individual patient. Deep tendon reflexes may be present or absent. With severe respiratory muscle paralysis, the patient may become cyanotic or exhibit narcosis from CO₂ retention.

- k. **Ricin:** Acute onset of fever, chest tightness, cough, dyspnea, nausea, and arthralgias occurs 4 to 8 hours after inhalational exposure. Airway necrosis and pulmonary capillary leak resulting in pulmonary edema would likely occur within 18–24 hours, followed by severe respiratory distress and death from hypoxemia in 36–72 hours. The clinical picture in intoxicated victims would depend on the route of exposure. After aerosol exposure, signs and symptoms would depend on the dose inhaled. Accidental sublethal aerosol exposures which occurred in humans in the 1940's were characterized by acute onset of the following symptoms in 4 to 8 hours: fever, chest tightness, cough, dyspnea, nausea, and arthralgias. The onset of profuse sweating some hours later was commonly the sign of termination of most of the symptoms. Although lethal human aerosol exposures have not been described, the severe pathophysiologic changes seen in the animal respiratory tract, including necrosis and severe alveolar flooding, are probably sufficient to cause death from ARDS and respiratory failure. Time to death in experimental animals is dose dependent, occurring 36–72 hours post inhalation exposure. Humans would be expected to develop severe lung inflammation with progressive cough, dyspnea, cyanosis and pulmonary edema. By other routes of exposure, ricin is not a direct lung irritant; however, intravascular injection can cause minimal pulmonary perivascular edema due to vascular endothelial injury. Ingestion causes necrosis of the gastrointestinal epithelium, local hemorrhage, and hepatic, splenic, and renal necrosis. Intramuscular injection causes severe local necrosis of muscle and regional lymph nodes with moderate visceral organ involvement.
- l. **Staphylococcal Enterotoxin B:** Latent period of 3–12 hours after aerosol exposure is followed by sudden onset of fever, chills, headache, myalgia, and nonproductive cough. Some patients may develop shortness of breath and retrosternal chest pain. Patients tend to plateau rapidly to a fairly stable clinical state. Fever may last 2 to 5 days, and cough may persist for up to 4 weeks. Patients may also present with nausea, vomiting, and diarrhea if they swallow the toxin. Presumably, higher exposure can lead to septic shock and death. Symptoms of SEB intoxication begin after a latent period of 3–12 hours after inhalation, or 4–10 hours after ingestion. Symptoms include nonspecific flu-like symptoms (fever, chills, headache, myalgias), and specific features dependent on the route of exposure. Oral exposure results in predominantly gastrointestinal symptoms: nausea, vomiting, and diarrhea. Inhalation exposures produce predominantly respiratory symptoms: nonproductive cough, retrosternal chest pain, and dyspnea. GI symptoms may accompany respiratory exposure due to inadvertent swallowing of the toxin after normal mucociliary clearance. Respiratory pathology is due to the activation of pro-

inflammatory cytokine cascades in the lungs, leading to pulmonary capillary leak and pulmonary edema. Severe cases may result in acute pulmonary edema and respiratory failure. The fever may last up to five days and range from 103 to 106°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 in exposure to biological weapons.

STANDARDS:

1. Emphasize the importance of follow-up care.

2. Discuss the procedure and process for obtaining follow-up appointments.
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. 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; 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 test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results

- b. follow-up tests may be ordered based on the results
- c. how results will impact or effect the treatment plan
- d. recommendations based on the test results

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.

BD - Bipolar Disorders

BD-C COMPLICATIONS

OUTCOME: The patient/family will understand the possible complications related to bipolar disorders.

STANDARDS:

1. Explain that child abuse, spousal abuse, school truancy, school failures, occupational failure, divorce, legal problems, or episodic antisocial behavior may occur during manic episodes or during those times with psychotic features.
2. Explain that individuals diagnosed with any of the bipolar disorders often have other associated problems, including Anorexia Nervosa, Bulimia Nervosa, Attention-Deficit Hyperactivity Disorder (refer to [“ADHD - Attention-Deficit/Hyperactivity Disorder](#)), Panic Disorder (refer to [“PANIC - Panic Disorder](#)), social phobia (refer to [“PHOB - Phobias](#)), and substance-related disorders (refer to [“AOD - Alcohol and Other Drugs](#)).
3. Discuss that individuals diagnosed with bipolar disorder have completed suicides at higher rates than the national average, especially during manic episodes.

BD-CM CASE MANAGEMENT

OUTCOME: The patient/family will understand the importance of integrated case management in treating bipolar disorders.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team 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](#).

BD-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.

2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

BD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of the Bipolar Disorder under consideration.

STANDARDS:

1. Explain that Bipolar Disorder is a chronic condition that has a biological component that often runs in families, but which can be managed with medication and therapy.
2. Explain that bipolar disorder includes either manic, hypomanic, or mixed episodes and almost always includes depressive episodes (**refer to [“DEP - Depressive Disorders”](#)**):
 - a. Discuss the symptoms and course of **Manic Episodes**:
 - i. A distinct period of abnormally and persistently elevated, expansive, or irritable mood lasting at least one week
 - ii. Inflated self-esteem or grandiosity
 - iii. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
 - iv. More talkative than usual or pressure to keep talking
 - v. Flight of ideas or subjective experience that thoughts are racing
 - vi. Distractibility
 - vii. Increase in goal-directed activity (e.g., sexually or socially, at work or school) or psychomotor agitation
 - viii. Excessive involvement in pleasurable activities that have high potential for painful consequences (e.g., unrestrained buying sprees, sexual indiscretions, or foolish business investments)
 - ix. Delusions or hallucinations are possible
 - b. Discuss the symptoms and course of **Mixed Episodes**:
 - i. Explain that in Mixed Episodes, the criteria are met both for a Manic Episode and for a Major Depressive Episode (except for duration) nearly every day for at least one week.
 - ii. Explain that the individual experiences rapidly alternating moods (sadness, irritability, euphoria) and is more likely to seek help due to increased dysphoria.

- c. Discuss the symptoms and course of **Hypomanic Episodes**, which are less severe in intensity and duration than Manic Episodes:
 - i. The distinct period of elevated, expansive, and irritable mood usually lasts at least four days.
 - ii. The list of additional symptoms are identical to those found in manic episodes above (# 2a), but hallucinations and delusions cannot be present.
 - iii. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic, and may require collateral information from significant others to confirm observable changes from normal functioning.
 - d. The symptoms for all of these episodes are not due to a general medical condition (e.g., hypothyroidism) or the direct physiological effects of a substance, including drug of abuse, medication, or other treatment.
 - e. The disturbance is sufficiently severe to cause marked impairment in social or occupational functioning, except in hypomanic episodes wherein the disturbance is less severe.
3. Explain that all the bipolar disorders have similar courses of development:
- a. The first Manic/Hypomanic episode will usually occur before the age of 40.
 - b. Most will have recurrent episodes.
 - c. Most manic episodes occur immediately before or after depressive episodes, and the episodes tend to decrease as the individual ages.
 - d. The majority of individuals will return to fully functional levels between episodes, although some may continue to experience mood lability and interpersonal/occupational difficulties.

BD-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in maintaining health with a diagnosis of Bipolar Disorder.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

BD-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

BD-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol, and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

BD-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.

BD-L LITERATURE

OUTCOME: The patient/family will receive literature about Bipolar Disorder.

STANDARDS:

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

BD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for coping with Bipolar Disorder.

STANDARDS:

1. Discuss lifestyle adaptations specific to Bipolar Disorder, which due to its chronic nature, includes a commitment to continuous mental health treatment and a medication regime.
2. Discuss that the family members may also require lifestyle adaptations to care for the patient, including safety measures should a patient become manic and/or potentially dangerous to self or others.
3. Discuss ways to optimize quality of life.
4. Discuss work, family, diet, and exercise adaptations that will be necessary due to the nature of mood stabilizing medications that can cause sedation and cravings for sweet food. (Refer to [“BD-N Nutrition”](#)).
5. Refer to community services, resources, or support groups, as available.

BD-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

BD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for Bipolar 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.

BD-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to Bipolar Disorder.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Refer to registered dietitian for MNT or other local resources as appropriate.

BD-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

BD-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of Bipolar Disorder.

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. Emphasize that full participation and follow-up is critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain that the therapist and the patient will establish goals and duration of therapy together.

BD-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to Bipolar Disorder, and the risk of suicide or other risky behaviors.

STANDARDS:

1. Discuss/review the safety plan with the patient and family, including the no-harm contract and emergency procedures for worsening conditions, e.g., suicidal or homicidal ideation, decompensation, and/or urges to engage in risky/dangerous behavior arise.
2. Discuss the importance of psychiatric hospitalization during crises to ensure patient safety.
3. Review the local resources and phone numbers, including the police, that may be utilized during a crisis and may assist in transportation and safety compliance.

BD-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect on the condition and precipitate depressive or manic episodes.
2. Explain the role of effective stress management in preventing and/or abating depressive or manic episodes.
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.

BD-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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.).

BD-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options for Bipolar Disorder.

STANDARDS:

1. Explain that both therapy and medication are recommended for Bipolar Disorder because of its lifelong nature, and that the patient's active participation in the treatment decisions is critical to a good outcome.
2. Explain that medication intervention is the crucial factor for maintaining mood stability in Bipolar Disorder. Psychotherapy may be supportive for chronic conditions or expressive and insight oriented.

3. Explain that medication and psychotherapy may also be useful in treating co-morbid conditions that exacerbate the course of Bipolar Disorder and may help improve quality of life.
4. Explain that therapists have different styles and orientations of therapy, and that no one approach has been shown to be more effective than others, although some styles may suit the patient better.

BITE - Bites, Animal and Human

BITE-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to animal and/or human bites.

STANDARDS:

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

BITE-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications animal and/or human bite.

STANDARDS:

1. Discuss common complications associated with this bite.
 - a. Infection
 - i. Cellulitis
 - ii. Osteomyelitis
 - iii. Viral, such as Rabies. Highest risk: bat, skunk, raccoon, fox, wild or unvaccinated dog
 - b. Mutilation
 - c. Loss of function
 - d. Phobias
 - e. Death
2. Explain that tetanus may be complication of the bite if immunizations are not current.

BITE-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

BITE-DP DISEASE PROCESS

OUTCOME: The patient/family will understand a basic understanding of the bite.

STANDARDS:

1. Discuss that bites can cause ripping and tearing of tissues, dislocation of joints, nerve damage, and breaking of bones.
2. Explain that bites can cause inoculation of bacteria, viruses, and debris into the wound site.

BITE-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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., purulent drainage, increasing redness, red streaks.
5. Discuss the availability of community resources and support services and refer as appropriate.

BITE-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to animal/human bite.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.

- a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

BITE-L LITERATURE

OUTCOME: The patient/family will receive literature about animal bites.

STANDARDS:

1. Provide the patient/family with literature on animal and human bites.
2. Discuss the content of the literature.

BITE-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
5. Discuss the potential need for rabies vaccine, immune globulin, and tetanus vaccine. Timely administration of these vaccines can be life saving.

BITE-P PREVENTION

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

STANDARDS:

1. Discuss the importance of supervising children around animals as well as avoiding and not feeding wild or stray animals.

2. Explain that animals need to be handled gently and never teased.
3. Discuss animal behaviors suggestive of rabies, e.g., aggression, foaming of mouth, nocturnal animals encountered during the day, loss of fear of humans.
4. Explain that aggressive, domesticated animals should be eliminated from the home
5. Discuss the importance of rabies vaccination for pets.

BITE-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management” on page 1297.](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

BITE-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

BITE-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 preventing infection: cleansing, antibiotic therapy, pain control, expected course of healing.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude. Explain that counseling by a mental health professional should be sought if symptoms of anxiety or depression arises, e.g., phobias, PTSD.

BITE-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound. **Refer to [“SWI - Skin and Wound Infections” on page 1609.](#)**

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 various alarms that may sound and the proper action to take.
3. 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 for blood transfusions.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

BL-L LITERATURE

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

STANDARDS:

1. Provide the patient/family with literature on 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. Explain that blood donors are carefully screened through a medical and social history before they donate blood and that donated blood is thoroughly tested to make sure it is free from disease or infection.
2. Explain that the laboratory carefully tests donated blood and the patient's blood to make sure that they are compatible.
3. 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.
4. 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.
5. 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, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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, blood disorders, or 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.
4. Explain that blood transfusions have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of transfusion as well as for not receiving the transfusion.

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, and 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 understand the benefits of breastfeeding.

STANDARDS:

1. Explain that benefits of breastfeeding for mothers including decreased risk of postpartum hemorrhage, enhanced uterine involution, decreased risk of some cancers and diabetes, delayed return of menses, improved postpartum weight loss, and improved bonding. If breastfeeding is not an option, other feeding choices are available. **Refer to [“FF - Formula Feeding”](#).**
2. Explain that the benefits to the baby include improved bonding, breast milk easier to digest, decreased diarrhea and constipation, decreased respiratory and ear infections, and decreased risk of obesity and diabetes.

BF-BC BREAST CARE

OUTCOME: The patient/family will understand how to manage breast engorgement and tenderness.

STANDARDS:

1. Explain the current techniques for management of engorgement and tenderness.
2. Explain some techniques for preventing and treating sore nipples (e.g., assure correct latch-on, apply cool moist tea bags). **Refer to [“BF-ON Latch-On”](#).**
3. Explain the techniques for treating and recognizing signs of infection (mastitis):
 - a. Need for frequent feeding to reduce risk of breast infections.

- b. Need to seek medical care when flu like symptoms (e.g., 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 prevent thrush (e.g., change breast pads often, let nipple air dry).
 - b. Recognizing the symptoms of thrush (candida), including red painful nipples, deep breast pain, 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 with hot soapy water that come in contact with the mother's nipple or the baby's mouth such as clothing, towels/linens, pacifiers, plastic nipples, and breast pump equipment.
 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 48 hours, in the refrigerator freezer for 3 months, and in the deep freezer for 6 months.

BF-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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 programs.
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 patient/family will understand the importance of follow-up for breastfeeding issues.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

BF-GD GROWTH AND DEVELOPMENT

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

STANDARDS:

1. Discuss the changes in a baby's growth and development as it relates to breastfeeding.
2. 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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a breast feeding help line.

STANDARDS:

1. Explain that a breast feeding help line may assist in answering questions regarding breast feeding and dealing with immediate issues.
2. Provide the help line phone number and hours of operation. IHS Breastfeeding Hotline 1-877-868-9473.
3. Explain how the help line works and what can be expected from calling and/or participating in the services.

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 the 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 to breastfeed 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, narcotics).
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. Encourage the abstinence from alcohol.
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. Discuss that the breastfeeding mother should consult a healthcare provider before starting any new prescribed or OTC medications and/or herbal/traditional therapies.

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. Explain that most OTC and prescribed medications are safe in breastfeeding, but some medications might pass through the breast milk and be harmful to the baby.
4. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
5. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
6. 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.

BF-MK MILK INTAKE

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

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, 8–12 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/family will understand the specific nutritional intervention(s) needed for breast feeding.

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 that is caused by build up of bilirubin in the blood. Explain that mild jaundice is harmless but high levels of bilirubin may cause brain damage.
2. Explain that 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.
3. Emphasize that parents should watch closely for jaundice and seek medical attention if jaundice is noticed.
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 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.

6. 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-on.

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, and a C- or U-hold may facilitate getting as much of the areola in the infant's mouth as possible.
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. Discuss the recommended introduction of solid foods:
 - a. Infants should not routinely be fed foods other than breastmilk or formula prior to 6 months of age except under the advice of a healthcare provider. Emphasize that, for some time after the introduction of solid foods, breastmilk/formula will still be the infant's primary source of nutrition.
 - b. 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.
 - c. Pureed/or finely mashed vegetables and fruits should be started no earlier than 6 months of age. Emphasize the need to wait 3–5 days between the addition of new foods to watch for adverse events from the foods. New foods might be rejected but may be accepted at a later time.
2. 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.
3. Discuss foods that should be avoided:

- a. Highly allergenic food such as peanut butter, chocolate, eggs, cow or goat milk, and citrus should not be fed until the infant is one year of age.
 - b. Explain that honey and syrups may contain botulism toxin and should not be fed before one year of age.
 - c. Foods that are choking hazards 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.
4. 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 and will stop when not interested. Do not force feed.
 - b. Some days babies eat a lot other days not as much.
 - c. No two babies eat the same.
5. Explain how to assess an infant's readiness to feed:
- a. Tongue thrusting is an indication of not being ready to eat solids.
 - b. Opens mouth when seeing food.
 - c. Closes lips over a spoon.
 - d. Keeps food in mouth instead of spitting it out.
 - e. Sits up alone without support.
6. 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 and effective stress management may increase the success of breastfeeding.
2. Explain that difficulty with breastfeeding may result in feelings of inadequacy, low self-esteem, or failure as a mother.
3. 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. Provide referrals as appropriate

4. 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.
5. 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, 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

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-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to burns.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with burns as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with burns, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).**
6. Refer to a mental health agency or provider.

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 fasciotomy and skin grafting, multi-organ failure, death.
4. Explain that scarring and/or tissue discoloration is common after healing of a burn.
5. Emphasize the importance of early treatment to prevent complications.
6. Explain that third degree or large body surface area burns are particularly prone to infection, dehydration, and other metabolic derangement that can be fatal.

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. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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, heat, steam, sunburns, chemical or electrical burns.
2. Explain the importance of assessing the degree and extent of damage to the injured tissues:
 - a. First-degree burns are those in which only the outer layer of skin (epidermis) is burned. The skin may show symptoms of redness, swelling and pain. The outer layer of skin hasn't been permeated. Treat a first degree burn as a minor burn unless it involves substantial portions of the 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 and may affect fat, muscle, and even bone. Areas may be charred black or appear dry and white. Difficulty with inhaling, 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 involve 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, and may result in pain, redness, swelling and 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.](#)**

BURN-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments
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.

BURN-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to burns.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet.
3. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

BURN-L LITERATURE

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

STANDARDS:

1. Provide 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 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

BURN-MNT MEDICAL NUTRITION THERAPY

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

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 and hydration for the healing of burns.

STANDARDS:

1. Review the nutritional needs of optimal health.
2. Discuss the importance of adequate nutrition and hydration in the repair of tissue. Explain the importance of full participation in the nutrition plan.
3. Discuss the current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
4. Refer to a registered dietitian 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 smoke detectors, carbon monoxide detectors, fire suppression systems, and ABC fire extinguishers in several locations throughout the home. Explain the user and proper maintenance of these devices.
2. Encourage routine practices of fire escape plan, chimney cleaning, and fireworks safety. Explain the importance of having fire escape ladders in multi-story homes.
3. Discuss the need to abstain from alcohol, tobacco, and other drugs when starting a fire.
4. Explain the importance of not smoking or use of open flames close to oxygen or flammable substances, such as gasoline.
5. Discuss the following safety issues as appropriate:
 - a. To prevent fire burns:
 - i. Don't smoke in bed and avoid leaving candles unattended.
 - ii. Practice home fire drills and "stop, drop, and roll" and install smoke detectors.

- iii. Discuss the danger of playing with matches, lighters, flames, or fireworks with children and family.
 - iv. Ensure heat lamps and other sources of heat have timers or appropriate safety devices.
 - v. Ensure that electrical wiring, outlets, and electrical devices are safe.
 - vi. Avoid the use of kerosene or gasoline as fire starters when burning debris piles.
- b. To prevent chemical burns:
- i. Child-proof cabinets and store chemicals out of the reach of children
 - ii. Use caution with storage and usage of cleaning materials
 - iii. Wear appropriate 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, avoid loose clothing, 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.
 - viii. Discuss the use of ceremonial sweats with the healthcare provider.
- 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. Keep electrical devices away from water and use ground fault circuit interrupter outlets near water sources.
 - iv. Don't modify electrical cords, outlets, or plugs.
 - v. Use power surge protectors.
6. Review the safe use of electricity and natural gas.

BURN-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

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, grease, or oil on a burn. Avoid the use of petroleum jelly or lotions.
 - a. Don’t use ice, because putting ice on a burn can cause frostbite, further damaging your skin. Cooling the skin with running water is best.
 - a. Don’t break blisters because 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.
 - a. 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](#).**

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 wound, e.g., decreased infection rate, and improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. **Refer to [“BURN-HY Hygiene](#).**
3. Explain the correct procedure for caring for this patient’s wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient’s wound.

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 many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is unable to provide guidance at the time that decisions need to be made.
3. Explain that Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences for care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer,) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.
6. Refer to [“ADV - Advance Directives](#).

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.

STANDARDS:

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-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to cancer.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with cancer as a life-altering illness that requires a change in lifestyle (**refer to [“CA-LA Lifestyle Adaptations](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with cancer, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#)**.
6. Refer to a mental health agency or provider.

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 other significant complications of treatment.
5. Discuss that pain may be a complication of the disease process or the therapy. **Refer to [“PM - Pain Management](#)**.

CA-CM CASE MANAGEMENT

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

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”](#).

CA-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

CA-DP DISEASE PROCESS

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

STANDARDS:

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 and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:

- a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the proper use and care of medical equipment, as appropriate. Participate in a return demonstration as appropriate.
 3. 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.

CA-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

CA-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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. Discuss the importance of self advocacy in obtaining services.

CA-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding cancer.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding cancer and dealing with issues.
2. Provide the help line phone number or Internet address (URL).
 - a. American Cancer Society: 1-800-ACS-2345
 - b. National Cancer Institute, Cancer Information Service: 1-800-4-CANCER [1-800-422-6237]; TTY (for deaf and hard-of-hearing callers) 1-800-332-8615

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-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change

- c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

CA-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to cancer.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

CA-L LITERATURE

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

STANDARDS:

1. Provide the patient/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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

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-OT Quit](#)**)
 - 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 (**refer to [“WH - Women's Health](#) and [“MH - Men's Health](#)**)
2. Discuss the importance of health surveillance, recommended screening and routine health maintenance for a patient of this age/sex, e.g., stool hemoccult testing, mammography, PSA. **Refer to [“WH-CRC Colorectal Cancer Screening](#), [“WH-](#)**

[MAM Mammogram](#), [“WH-PAP Pap Smear / Pelvic Exam](#), [“MH-BE Breast Exam](#), [“MH-CRC Colorectal Cancer Screening](#), [“MH-PRS Prostate Health](#), [“MH-TSE Testicular Self-Exam](#).

3. Emphasize the importance of the early cancer detection. Encourage the patient to come in early if signs of cancer are detected (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).

CA-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care after a diagnosis of cancer.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies

- f. childcare
- 5. Refer for medical and psychosocial support services for any risk factor identified.

CA-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

CA-PRO PROCEDURE

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 of 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 for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

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. **Refer to [“AF-REF Referral Process](#).**
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](#).**
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 test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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, surgery, 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.

CELIAC - Celiac Disease

CELIAC-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of celiac disease.
2. Discuss changes to anatomy and physiology as a result of celiac disease:
 - a. Celiac disease is a lifelong inflammatory condition of the GI tract that affects the small intestine.
 - b. Villi are tiny finger-like intrusion lining the small intestine and are responsible for absorption of nutrients from food. Gluten causes the immune system to damage and destroy villi. Without health villi the person becomes malnourished no matter how much food one eats.
 - c. Celiac disease may affect genetically predisposed individuals.
3. Discuss the impact of these changes on the patient's health or well-being. Discuss the need for dietary changes related to celiac disease (**refer to [“CELIAC-N Nutrition](#)**).

CELIAC-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to celiac disease.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with celiac disease as a life-altering illness that requires a change in lifestyle (**refer to [“CELIAC-LA Lifestyle Adaptations](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with celiac disease, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#)**.
6. Refer to a mental health agency or provider.

CELIAC-C COMPLICATIONS

OUTCOME: The patient/family will understand common complications management of celiac disease.

STANDARDS:

1. Review the common complications associated with celiac disease, e.g., malabsorption of nutrients, diarrhea, anemia, short stature, osteoporosis, lymphoma, Type 1 diabetes, and a variety of neurological disorders and other autoimmune diseases.
2. Explain that complications are worsened by not strictly following gluten-free diet.
3. Explain that untreated Celiac Disease may result in infertility or miscarriages.

CELIAC-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.
 - a. Patient responsibilities include self management of gluten-free lifestyle and self monitoring of foods, cosmetics, medications etc.
 - b. Family/caregiver responsibilities include support of the gluten-free lifestyle.
 - c. Explain that registered dietitian is essential in planning and implementing a patient's gluten-free lifestyle
2. 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”](#).

CELIAC-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of celiac disease.

STANDARDS:

1. Explain that celiac disease is a genetic, chronic, malabsorption disease.
2. Discuss some common symptoms of celiac disease, e.g., chronic or intermittent diarrhea, dumping syndrome, abdominal pain, weight loss, failure to thrive (children), loss of appetite. Symptoms can be corrected with strict adherence to a gluten-free lifestyle.

3. Review the disease process of celiac disease. Emphasize that the destructive process can be halted and healing will take place with strict adherence to gluten-free lifestyle. Indicate that complications caused by long term malabsorption may require medication and/or supplements.
4. Explain that the onset of celiac disease may occur at any age after introduction of grains (WBRO). After onset, celiac disease lasts a lifetime, making long-term management of diet and symptoms of the disease very important.

CELIAC-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

CELIAC-HELP HELP LINE

OUTCOME: The patient/family will understand some sources of information and support in living with celiac disease.

STANDARDS:

1. Refer to a registered dietitian and national support groups and local support groups, as well as providing information about gluten-free manufacturers and producers, websites of celiac information, recipes, and references.
2. Explain that national support groups include:

Celiac Sprue Association
PO Box 31700
Omaha, NE 68131-0700
toll free phone: 877-272-4272

<http://www.csaceliacs.org>

This is the largest patient based non-profit with chapters and contacts throughout the United States.

Gluten Intolerance Group

31214 124th Ave SE
Auburn, WA 98092-3667

<http://gluten.net>

Celiac Disease Foundation
13251 Ventura Blvd. #1
Studio City, CA 91604
Phone: 818-990-2354

<http://celiac.org>

American Celiac Society
PO Box 23455
New Orleans, LA 70183-0455
Phone: 504-737-3293

<http://americanceliasociety.org>

CELIAC-L LITERATURE

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

STANDARDS:

1. Provide the patient/family with literature on celiac disease.
2. Discuss the content of the literature.
3. Discuss creditable resources for celiac disease.

CELIAC-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

1. Discuss that the mandatory treatment for celiac disease is always a gluten-free diet.
2. Explain how exercise and social involvement may decrease the depression and anger that may be associated with celiac disease.
3. Discuss that, in some cases, patients may need to be on long-term nutrition support, which may include nutritional supplementation, TPN, or enteral feedings.

CELIAC-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 full participation with the medication plan and that this is the patient's responsibility. Emphasize the importance of taking medications as prescribed, e.g., avoiding overuse, under use, or misuse
5. Discuss the importance of keeping a list of all current prescriptions and OTC medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.
6. Explain the importance of consulting with a healthcare provider prior to using OTC medications, or other non-prescribed or illicit drugs, due to:
 - a. Some medications may contain Wheat, Bran, Rye, Oats (WBRO) and milk products. WBRO in the medications of a newly diagnosed celiac patient may reduce effectiveness of the medication and delay response to diet and return to health.
 - b. Medications containing iodine may be an irritant for those with the dermatitis herpetiformis manifestation of celiac disease.

AOD-MNT MEDICAL NUTRITION THERAPY

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

CELIAC-N NUTRITION

OUTCOME: The patient/family will understand that maintaining a healthy weight and a gluten-free lifestyle is essential.

STANDARDS:

1. Explain that eating a variety of gluten-free foods is important to maintaining a healthy weight and providing essential nutrients.
2. Explain that even though gluten rarely appears on a food label or in the ingredients listing, the product may include gluten. Avoid foods that contain wheat, bran, rye, or oats. Refer to [“CELIAC-L Literature”](#).
3. Discuss the importance of intake of water to maintain hydration.
4. Discuss avoidance alcoholic beverages made from wheat, bran, rye, or oats.
5. Refer to a registered dietitian.

CELIAC-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.

4. Discuss the importance of advanced family planning (reproductive planning).
Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

CELIAC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

CELIAC-TX TREATMENT

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

STANDARDS:

1. Explain that the treatment for celiac disease is a gluten-free diet. Improvement can begin within a few days of starting a gluten-free diet. The small intestine usually heals in 3 to 6 months in children but may take several years in adults. To stay well people with celiac disease must avoid gluten for the rest of their lives. Emphasize

the importance of active participation by the patient/family in the development of and participation with treatment plan.

2. Explain the risk/benefit of treatment and non-treatment.
3. Discuss the importance of maintaining a positive mental attitude.

CVC - Central Line Catheter

CVC-C **COMPLICATIONS**

OUTCOME: The patient/family will understand the potential, common, and important complications of central venous catheters.

STANDARDS:

1. Explain that complications may occur during insertion or treatment regardless of the care taken.
2. Discuss the most common complications and measures that will be taken to prevent them, e.g.:
 - a. Hemo/pneumothorax
 - b. Central line associated bloodstream infections
 - c. Nerve damage
 - d. Thrombosis (clotting) of the catheter or the blood vessel

CVC-DP **DISEASE PROCESS**

OUTCOME: The patient/family will understand the basic insertion and use for the specific central venous catheter utilized.

STANDARDS:

1. Discuss the reason the central venous catheter is proposed.
2. Discuss the specific selection of central venous catheters, e.g. single lumen, multiple lumen, peripherally inserted central catheter, and the probable selection of sites, e.g. subclavian, internal jugular, antecubital.

CVC-EQ **EQUIPMENT**

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction

- f. Infection control principles, including proper disposal of associated medical supplies
- g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

CVC-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the use of the central venous catheter.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

CVC-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of the central venous catheter.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

CVC-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to the central venous catheter.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.

- b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
- c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

CVC-L LITERATURE

OUTCOME: The patient/family will receive literature about the central venous catheter.

STANDARDS:

1. Provide the patient/family with literature on the central venous catheter.
2. Discuss the content of the literature.

CVC-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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. If medications are to be administered on an outpatient basis, explain and demonstrate the proper procedure for administration. Emphasize the importance of and procedure for hand hygiene in relation to administration.

CVC-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

CVC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:

- a. meaning of the test results
- b. follow-up tests may be ordered based on the results
- c. how results will impact or effect the treatment plan
- d. recommendations based on the test results

CVC-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the catheter insertion site, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the catheter insertion site and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's catheter insertion site, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary catheter insertion site techniques.
4. Detail the supplies necessary for care of this catheter insertion site (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's catheter insertion site.

CERP - Cerebral Palsy

CERP-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, movement, toileting, and walking) and discuss how the patient's ability to perform ADLs affects the 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. This may include information about accessing social services, getting medical care, having relationships, shopping, cooking meals, staying out of trouble, structuring leisure time, keeping clean, and using transportation.

CERP-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The parents/caregivers will understand anatomy and physiology as it relates to cerebral palsy.

STANDARDS:

1. Explain that cerebral palsy is neurological dysfunction resulting from brain damage to motor centers before, during, or after birth. Cerebral palsy is not caused by problems with the muscles or nerves, but with the brain's ability to adequately control the body.
2. Discuss the appropriate type of palsy:
 - a. Spastic Paralysis (difficult, stiff movement)
 - b. Ataxic (loss of depth perception and balance)
 - c. Athetoid/Dyskinetic (uncontrolled or involuntary movements)
 - d. Mixed (a mix of two or more of the above)
3. Discuss the impact of these changes on the patient's health or well-being.

CERP-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The parents/caregivers will understand the behavioral, emotional, and psychological components of cerebral palsy.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of learning a child has been diagnosed with cerebral palsy as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions. Explain the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#).**
6. Refer to a mental health agency or provider.

CERP-C COMPLICATIONS

OUTCOME: The patient/family will understand the common complications of cerebral palsy.

STANDARDS:

1. Discuss that complications occur in the part of the body affected by muscle weakness:
 - a. problems with breathing because of postural difficulties
 - b. spasticity and contractures
 - c. skin disorders because of pressure sores
 - d. bladder problems
 - e. seizures (**refer to [“SZ - Seizure Disorder”](#)**)
 - f. communication difficulties
 - g. osteopenia
 - h. osteoporosis
 - i. fractures
 - j. functional gastrointestinal abnormalities contributing to bowel obstruction, vomiting, and constipation
2. Discuss the possibility of learning disabilities.
3. Discuss that difficulties in feeding may result in malnutrition and may require nutrition support interventions. **Refer for [“CERP-MNT Medical Nutrition Therapy”](#).**

4. Discuss that adult morbidity and mortality from ischemic heart disease, cerebrovascular disease, cancer, and trauma are higher in patients with cerebral palsy than in the general population.

CERP-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving optimal socialization and education, as well as 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”](#).**
4. Discuss the importance of care coordination for issues on transportation, special education, school, juvenile justice, diagnostic clinics, and parent respite.

CERP-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The parents/caregivers will understand the impact and influences that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

CERP-DP DISEASE PROCESS

OUTCOME: The parents/caregivers will understand the disease process of cerebral palsy.

STANDARDS:

1. Explain that cerebral palsy is a group of chronic conditions affecting body movement and muscle coordination.

2. Explain that the brain injury or problem that causes cerebral palsy is not progressive. However, as the child ages, and would be expected to reach new milestones, failure to achieve these milestones would make the child appear to develop new symptoms or have worsening of existing symptoms. This is why some babies born with cerebral palsy do not show clear signs of it right away.
3. Explain that the signs/symptoms can range from mild to severe. Pay close attention to the presence of the following problems with:
 - a. fine motor skills, including handling scissors, using crayons, buttoning a shirt, and any other movement that requires fingers and hands
 - b. gross motor skills, including walking, riding a tricycle, kicking a ball, and other movements that require legs and trunk stability
 - c. sitting upright, which requires normal muscle tone
 - d. shaking, tremors, or uncontrollable jerking of arms or legs
 - e. moving from one position to another
 - f. weak muscles
 - g. drooling, weakened facial muscles in the face, loss of tongue control
 - h. sucking, chewing, or swallowing

CERP-EQ EQUIPMENT

OUTCOME: The parents/caregivers will understand and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

CERP-EX EXERCISE

OUTCOME: The parents/caregivers will understand the role of physical activity in cerebral palsy.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

CERP-FU FOLLOW-UP

OUTCOME: The parents/caregivers will understand the importance of follow-up in the treatment of cerebral palsy.

STANDARDS:

1. Emphasize the importance of follow-up care. Outcomes are better for children with special needs if they have family centered continuity of care, planned care visits, and case management within the concept of the medical home. **Refer to [“CERP-CM Case Management”](#).**
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

CERP-GD GROWTH AND DEVELOPMENT

OUTCOME: The parents/caregivers will understand the factors that contribute to growth and development for children, adolescents, and adults with cerebral palsy.

STANDARDS:

1. Discuss issues affecting physical growth which may or may not be present, to include abnormal facial features, growth deficits (height, weight, or both), and central nervous system (structural, neurologic, or functional).
2. Discuss factors affecting development:

- a. Cerebral palsy deficits are fixed, and not progressive.
- b. There is no cure for cerebral palsy, but research shows that early intervention treatment services can improve a child's development.
- c. Early intervention services help children from birth to 3 years of age (36 months) learn important skills.
- d. Services include therapy to help the child talk, walk, and interact with others

CERP-HELP HELP LINE

OUTCOME: The parents/caregivers will understand how to access and benefit from a help line or Internet website regarding cerebral palsy.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding cerebral palsy and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

CERP-HM HOME MANAGEMENT

OUTCOME: The parents/caregivers will understand the home management of cerebral palsy.

STANDARDS:

1. Explain the home management techniques, especially with regards to physical changes in the home and alterations for handicap accessibility.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

CERP-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The parents/caregivers will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:

- a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

CERP-L LITERATURE

OUTCOME: The parents/caregivers will receive literature about cerebral palsy.

STANDARDS:

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

CERP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The parents/caregivers will understand the factors that contribute to better outcomes for children, adolescent, and adults with cerebral palsy.

STANDARDS:

1. Review the lifestyle areas that may require adaptations (e.g., home, school, job, physical activity, recreational/leisure activity, communication, social skills, and driving, etc.). Discuss that effective intervention for individuals with cerebral palsy often requires restructuring the home, community, and school environments.
2. Explain that the interventions for cerebral palsy require on-going family/caregiver involvement and continued advocacy for the child.
3. Explain that the use of multiple, consistent, persistent interventions are necessary for a good outcome; communication should be simple, direct, and concrete.
4. Discuss that behavioral and developmental problems associated with cerebral palsy may exacerbate parental stress and marital problems. Explain that appropriate help should be sought as soon as the problem is identified.
5. Refer to Social Services, Behavioral Health, Physical Therapy, Speech Therapy, or other rehabilitative services and/or community resources as appropriate.

CERP-M MEDICATIONS

OUTCOME: The parents/caregivers 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

CERP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The parents/caregivers will understand the specific nutritional intervention(s) needed for cerebral palsy.

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.

CERP-N NUTRITION

OUTCOME: The parents/caregivers will understand nutrition, as it relates to cerebral palsy.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.

2. Discuss the importance of adequate fluid intake and small frequent feedings using soft or puree food textures as appropriate. Discuss that some patients may require feeding assistance.
3. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal. Use of a general multivitamin-mineral supplement is recommended.
4. Review food consistency. Emphasis that foods should be easy to chew and swallow as appropriate. Discuss the appropriate use of liquid thickeners to minimize choking.
5. Discuss the need for nutrition support or use of high elemental formulas to correct malnutrition and to meet energy needs. Refer to registered dietitian for MNT as appropriate.

CERP-P PREVENTION

OUTCOME: The parents/caregivers will understand the ways to prevent cerebral palsy.

STANDARDS:

1. Describe some ways to alter risk factors:
 - a. To reduce the risk of premature birth and low birth weight, obtain early prenatal care, avoid tobacco, avoid alcohol and other drugs. **Refer to [“PN - Prenatal”](#).**
 - b. To reduce the risk of infection of the mother with Rubella or other viral diseases in early pregnancy, obtain appropriate immunizations. **Refer to [“PN - Prenatal”](#).**
 - c. To reduce the bacterial meningitis from Group B Strep, get tested as part of prenatal care. **Refer to [“PN - Prenatal”](#).**
 - d. To reduce the complication from neonatal jaundice, seek immediate care. **Refer to [“NJ - Neonatal Jaundice”](#).**
2. Discuss prevention of trauma to the brain, e.g., from motor vehicle collisions, falls, or child abuse.

CERP-PM PAIN MANAGEMENT

OUTCOME: The parents/caregivers will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management”](#).**

3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

CERP-PRO PROCEDURE

OUTCOME: The parents/caregivers 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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

CERP-S SAFETY

OUTCOME: The parents/caregivers will understand safety as it relates to cerebral palsy.

STANDARDS:

1. Discuss the use of a properly secured car seat every time the child rides in a vehicle. Children not requiring a car seat or booster seat should be secured with a seat belt. Children under the age of 12 should not ride in the front seat of the car.
2. 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.
3. Provide information to reduce the risk of falls. Some ideas include:
 - a. wearing non-skid slippers when out of bed may prevent slipping and falling

- b. using side rails in a safe manner, as appropriate
- c. removing obstacles, such as throw rugs, wires/cords across the floor, objects on the floor, non-level floors, wet or moist floors, uneven carpeting, pets in the home, small children playing on the floor
4. Discuss that persons with cerebral palsy are at higher risk for being exploited, abused, and neglected. **Refer to [“ABNG - Abuse and Neglect \(child or elder\)”](#).**

CERP-SHS SECOND-HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregivers will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Define that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, and many other carcinogens.
3. Explain the increased risk of illness when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia, SIDS, and lung cancer.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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-OT Quit”](#).**

CERP-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in cerebral palsy.
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
4. Provide referrals as appropriate.

CERP-TE TESTS

OUTCOME: The parents/caregivers will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

CERP-TX TREATMENT

OUTCOME: The parents/caregivers 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 participation in the treatment plan.

2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

CVA - Cerebrovascular Disease

CVA-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family 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 many persons are not able to make their own decisions when ill. The advance directive and its role in maintaining a sense of control in the patient's medical care and decisions.
2. Explain that this statement of preferences is only used to guide decision making if the patient is able to provide guidance at the time that decisions need to be made.
3. Explain that the Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences of care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.

CVA-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

CVA-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to cerebrovascular disease.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with cerebrovascular disease as a life-altering illness that requires a change in lifestyle (**refer to [“CVA-LA Lifestyle Adaptations”](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with cerebrovascular disease, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#)**.
6. Refer to a mental health agency or provider.

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.
2. Describe the signs/symptoms of common complications of cerebrovascular disease.
3. Discuss the importance of following the prescribed treatment plan including physical therapy, medications and rehabilitation in maximizing potential.
4. Discuss common complications of cerebrovascular disease, e.g., loss of function, loss of speech, confusion, loss of independence.
5. 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”](#).**

CVA-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

CVA-DP DISEASE PROCESS

OUTCOME: The patient will understand the cerebrovascular disease.

STANDARDS:

1. Discuss the cerebrovascular disease process and types strokes.
2. Explain the risk factors related to the development of cerebrovascular disease.
3. Discuss the signs and symptoms of cerebrovascular disease.

CVA-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction

- f. Infection control principles, including proper disposal of associated medical supplies
- g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

CVA-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

CVA-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding cerebrovascular disease.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding cerebrovascular disease and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

CVA-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

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-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to cerebrovascular disease.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

CVA-L LITERATURE

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

STANDARDS:

1. Provide the 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. Discuss lifestyle adaptations specific to cerebrovascular disease.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

CVA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the ways to prevent future strokes: linolenic acid from walnuts, canola, and soybean oils may be protective. Increased fruit and vegetable intake.
4. Review the disease process of cerebrovascular disease related to uncontrolled diabetes, uncontrolled hypertension, uncontrolled dyslipidemia.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

CVA-P PREVENTION

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

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.

CVA-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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:

- a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

CVA-S SAFETY

OUTCOME: The patient and/or appropriate family member(s) will understand safety as it relates to cerebrovascular disease.

STANDARDS:

1. Discuss the importance and proper use of mobility devices.
2. Explain importance of body mechanics and proper lifting techniques to avoid injury.

CVA-SCR SCREENING

OUTCOME: The patient/family will understand the proposed screening including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed screening, e.g., guaiac, blood pressure, hearing, vision, development, mental health.
2. Explain the process and what to expect after the screening.
3. Emphasize the importance of follow-up care.

CVA-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management to decrease high blood pressure and increased stress can interfere with treatment of the cerebrovascular disease.
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.

CVA-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

CVA-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 participation with treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

CWP - Chemical Weapons

CWP-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of affected body systems.
2. Discuss changes to anatomy and physiology as a result of exposure to chemical weapons.
3. Discuss the impact of these changes on the patient's health or well-being.

CWP-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components as it relates to chemical weapons exposure.

STANDARDS:

1. Discuss normal age- and developmentally-appropriate behavioral reactions to trauma. Discuss the common difficulty in coping with the initial impact of being diagnosed with chemical weapons exposure as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with chemical weapons exposure, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil. Explain that Acute Stress Disorder (ASD) may last up to 4 weeks, and Post-Traumatic Stress Disorder (PTSD) is considered when symptoms last more than four weeks, although delayed onset can occur months to years later.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components. Explain that with proper interventions, treatment and support, long-term stress disorders and psychiatric morbidity can be mitigated and possibly prevented.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).**
6. Refer to a mental health agency or provider.

CWP-C COMPLICATIONS

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

STANDARDS:

1. Discuss common complications of chemical weapons exposure and the common signs and symptoms which are relevant to the patient's exposure.
 - a. Nerve agents (Organophosphates or Sarin): These chemicals affect the nervous system, and may lead to multi-organ system failure and death.
 - b. Blister agents (vesicants such as nitrogen or sulfur mustard): Vesicants are chemicals that cause blistering of the skin, irritation and inflammation of the airways, vomiting, and diarrhea. This may lead to disfiguring wounds, infection, respiratory failure, dehydration, and/or death. Exposure to blister agents may also cause psychological distress over disfigurement.
 - c. Cyanide: Cyanide forms a gas when mixed with acids. Large doses of cyanide can kill within minutes. Smaller doses affect the central nervous system, for example, causing seizures. Exposure to low doses may cause anxiety, confusion, nausea, feeling of weakness, giddiness, hyperventilation.
 - d. Pulmonary agents: Chemicals such as phosgene and perfluoroisobutylene cause swelling and fluid retention in the lungs. The build-up of fluid in the lungs may lead to respiratory failure and death.
 - e. Other: Blood agents, toxic metals, organic solvents, etc. each have their own unique complications.
2. Explain that behavioral health complications which may result from exposure to trauma may also include maladaptive and impaired thoughts, feelings, and behaviors in response to traumatic events such as Acute Stress Disorder (ASD, which may last up to 4 weeks), or Post-Traumatic Stress Disorder (PTSD, in which symptoms last more than four weeks, although delayed onset can occur months to years later). (Refer to [“CWP-BH Behavioral and Emotional Health.”](#))

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”](#).

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. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

CWP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand chemical weapon exposure.

STANDARDS:

1. Discuss that chemicals used for terrorism are man-made, unlike naturally occurring biological agents. Most chemical terrorism agents are liquids that are put into the air and then absorbed through the skin or breathed into the lungs.
2. Explain that the effects of the chemical agent on the person will depend on the type of agent to which the patient was exposed.
 - a. Nerve agents (Organophosphates or Sarin): These chemicals affect the nervous system. They cause confusion, disorientation, delusions, and hallucinations. They also cause blurred vision, a rapid heart rate, and slurred speech.
 - b. Blister agents (Vesicants): Examples include mustard gas, Lewisite, and phosgene oxime. Vesicants are chemicals that cause blistering of the skin, irritation and inflammation of the airways, vomiting, and diarrhea.
 - c. Cyanide: Cyanide forms a gas when mixed with acids. Large doses of cyanide can kill within minutes. Smaller doses affect the central nervous system, for example, causing seizures.
 - d. Pulmonary agents: Chemicals such as phosgene and perfluoroisobutylene cause swelling and fluid retention in the lungs. They don't have any effect until several hours after exposure, when you begin to cough and have trouble breathing. Hours to days later, as the chemicals cause more swelling and inflammation, more fluid builds up in the lungs. Eventually the fluid can make it so hard to breathe that it causes death.

- e. Other: Blood agents, toxic metals, organic solvents, etc. each have their own unique mechanisms of action.

CWP-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity, to include limitation of physical activity if indicated, in chemical weapons exposure.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Explain that people who are exposed to certain chemical agents (especially pulmonary agents) should be kept at rest and not even allowed to walk because exertion makes the symptoms worse.
3. Discuss the benefits of any physical activity later in recovery, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
4. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
5. Discuss the appropriate frequency, intensity, time, and type of activity.
6. Refer to community resources as appropriate.

CWP-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of exposure to chemical weapons.

STANDARDS:

1. Emphasize the importance of follow-up care, to include attention to physical, behavioral, and spiritual health.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

CWP-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding chemical weapons exposure.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding chemical weapons exposure and dealing with issues.
2. Provide the help line phone number or Internet address (URL), such as www.cdc.gov for the most current information, and reporting procedure. People can contact one of the following:

Regional poison control center: 1-800-222-1222

CDC Public Response Hotline: 1-800-CDC-INFO

CWP-L LITERATURE

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

STANDARDS:

1. Provide the patient/family with literature on exposure to chemical weapons exposure.
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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

CWP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for exposure to chemical weapons.

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 AND DECONTAMINATION

OUTCOME: The patient/family will understand ways to reduce risk of exposure to chemical weapons, particularly use of contact barriers and decontamination of clothes and skin.

STANDARDS:

1. Discuss the importance of using appropriate protective barriers if coming into contact with an individual who may have been exposed to chemical weapons.
2. Discuss the process of decontamination. Chemical decontamination has two primary goals. First, decontamination helps prevent further harm to the patient from the chemical exposure. Second, decontamination helps protect first responders and health care providers, and maintains the viability of the treatment center. Mismanagement may result in illness in health care providers and contamination of the treatment center. Severe contamination may necessitate departmental closure, which is potentially catastrophic in a mass casualty incident.
3. Explain the process of decontamination. Methods of patient decontamination include chemical dilution and chemical inactivation. Decontamination is time consuming and requires resources. Nerve agents and substances causing injury to the skin and tissue are easily soluble in, and penetrate many different types of material, which renders decontamination more difficult. If chemical weapons

agents have penetrated sufficiently deep, then toxic gases can be released from the material for long periods.

CWP-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

CWP-TE TESTS

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

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

CWP-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
 - a. Nerve agents: There is an antidote, but it must be given every hour until the effects of the chemical wear off--usually for several hours to a day or two, depending on how much chemical the patient was exposed to.
 - b. Blister agents: There are antidotes that limit or stop the effects of some but not all, of these chemicals.
 - c. Cyanide: There are antidotes to cyanide poisoning.
 - d. Pulmonary agents: People who are exposed to these chemicals should be kept at rest and not even allowed to walk because exertion makes the symptoms worse.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

CWP-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

CP - Chest Pain

CP-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of chest pain.
2. Discuss the pathology that results in chest pain, such as inflammation, spasm, or blockage of the esophagus, stomach, heart, chest wall, or lungs.
3. Discuss the impact of these changes on the patient's health or well-being.

CP-C COMPLICATIONS

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

STANDARDS:

1. Discuss common complications of chest pain, for various etiologies, e.g., cardiovascular, pulmonary, musculoskeletal, gastrointestinal.
2. Describe the signs/symptoms of common complications of 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-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity as it relates to chest pain.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.

3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

CP-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize 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 and process for obtaining follow-up appointments.
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-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for chest pain.

STANDARDS:

1. Discuss lifestyle adaptations specific to recurrent chest pain.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

CP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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 may be 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 dietitian for MNT as appropriate.

CP-P PREVENTION

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

STANDARDS:

1. Discuss things that can trigger chest pain, as it pertains to this chest pain.
2. Discuss healthy lifestyles that can help to preserve normal function.

CP-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

CP-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management 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”](#), [“GAD - Generalized Anxiety Disorder”](#).**
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.

CP-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

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

CHN-CAR CAR SEATS AND AUTOMOBILE SAFETY

OUTCOME: The parents/caregiver will understand measures that will improve car safety.

STANDARDS:

1. Stress the importance that all occupants in the vehicle use appropriate safety belt or safety seat - allow no exceptions.
 - a. Stress the use of a properly secured, NTSB approved rear facing car seat EVERY TIME the newborn rides in a vehicle.
 - b. Stress the importance of never using a cradle board to secure the newborn in a vehicle.
 - c. The car seat should be in the middle of the back seat of the vehicle.
2. Discuss avoiding behaviors that might divert attention from driving, such as smoking, cell phone use, eating, CDs and radios, or unruly kids.
3. Emphasize the importance of never driving while under the influence of alcohol, street drugs, sedatives or over-the-counter drugs that can cause drowsiness.
4. Discuss the need to secure or remove any loose items in the car that can fly around and hurt the baby/small child if you stop suddenly or are in an accident.
5. Discuss the potential dangers of leaving an newborn/child alone in a vehicle, e.g., vehicle gears shifted and car goes in motion, injury caused by power windows or sunroof, keys locked in vehicle with child, heat/cold exposure, abduction or child wandering away.

CHN-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The parents/caregiver will understand the impact and influences that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.
3. Discuss the dangers of prolonged exposure of the newborn to ceremonial practice of burning sweet grass, sage, cedar, or tobacco.

4. Stress the importance of never using a cradle board to secure the newborn in a vehicle.

CHN-ECC EARLY CHILDHOOD CARIES

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

STANDARDS:

1. Explain early childhood caries is caused when liquids containing sugar are left in a baby's mouth for long or frequent periods of time.
2. 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.
 - a. Avoid giving bottles when the baby is lying down. Bottle should never be propped.
 - b. Feed baby formula or breast milk PRIOR to nap or bedtime. There should be nothing in the bottle except formula, breast milk, or electrolyte solution.
 - c. If baby must use a bottle to fall asleep, use a pacifier or give a bottle of plain water instead, removing it after baby goes to sleep.
 - d. Use only clean pacifiers; never dip a pacifier in any type of sugar substance, especially honey.
 - e. Clean baby's gums after each feeding; wipe and massage the gums with a clean wet gauze pad or cloth.
3. Explain preventive measures family members can take to avoid spreading germs that cause cavities to small children:
 - a. Review oral hygiene habits the whole family should practice.
 - b. Don't put anything in baby's mouth that has been in another person's mouth.

CHN-FU FOLLOW-UP

OUTCOME: The parents/caregiver will understand the importance of keeping routine well child visits.

STANDARDS:

1. Emphasize the importance of follow-up care and well child visits. Discuss that well child visits are important to follow growth and development, to screen for disease, and to update immunizations.
2. Discuss the procedure and process for obtaining follow-up appointments and well child visit. Inform the patients/family of the timing of the next well child visit.

3. Emphasize that full participation of the treatment plan is the responsibility of the parents/caregiver.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

CHN-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent(s) will understand a newborn's growth and development.

STANDARDS:

1. Discuss the various newborn reflexes.
2. Explain the limits of neuromuscular control in newborns.
3. Review communication methods babies may use and the importance of caregivers understanding their babies behavior to help care for the newborn in the best way:
 - a. the myriad of "noises" newborns can make and how to differentiate between normal sounds and signs of distress
 - b. facial and body cues that babies may use to communicate what they want or need. For example:
 - i. when hungry, nuzzles against breast, moves fist to mouth, makes sucking sounds
 - ii. when sleepy, yawns and stares off into space
 - iii. when in distress, scrunches up face and makes rigid arm and leg movements
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.
6. Discuss normal bowel habits of the newborn.
 - 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).

CHN-HELP HELP LINE

OUTCOME: The parents/caregiver will understand how to access and benefit from a help line or Internet website regarding child health newborn care.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding child health newborn care and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

CHN-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The parents/caregiver will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices for the baby.
2. Explain healthy lifestyle choices of the parents/caregiver (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle. Discuss the benefits of the parents'/caregivers' healthy lifestyle on the newborn.
3. Explain the need to protect the newborn from illness or injury caused by exposure to:
 - a. crowds (risk of infection)
 - b. loud noises (risk hearing damage)
 - c. pets (risk of infection or injury, e.g., smothering, bites)
 - d. temperature extremes (newborns can't control body temperature well)
4. Stress the dangers of fever ($>100.4^{\circ}$ F) in the newborn period and the importance of seeking immediate medical care. Discuss that rectal temperature is a reliable method of temperature measurement in newborns. **Refer to [“NF - Neonatal Fever”](#).**
5. Discuss signs/symptoms of illness and when to seek medical care, e.g., fever $>100.4^{\circ}$ F, seizure, certain rashes, irritability, lethargy, failure to eat, vomiting, diarrhea, jaundice, dehydration, apnea, cyanosis. **Refer to [“NF - Neonatal Fever”](#).**
6. Discourage use of medications in the newborn period.

CHN-HY HYGIENE

OUTCOME: The parents/caregiver will understand hygiene issues in the newborn.

STANDARDS:

1. Discuss the importance of hand washing in infection prevention.
 - a. Explain the importance of hand washing especially during bottle feeding preparation and eating, diaper changing, toilet use, and anytime before caring for the newborn.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Discuss the care of the circumcised and uncircumcised penis in boys. Discuss the normal vaginal discharge or bleeding that baby girls may have.
3. Discuss newborn hygiene, e.g., bathing, cord care, avoidance of powders, skin and nail care, appropriate clothing for the season and environment.
4. Review the risks of exposing immunocompromised and high-risk persons (newborns, infants, and elderly) to communicable diseases.
5. Stress the importance of clean bottles, nipples, and pacifiers. **Refer to [“CHN-HY Hygiene”](#).**

CHN-IM IMMUNIZATIONS

OUTCOME: The parents/caregiver will understand the immunizations necessary for preventing communicable diseases. **Refer to [“IM - Immunizations”](#).**

STANDARDS:

1. Discuss the schedule for recommended immunizations and illness they prevent.
2. Discuss the side effects and potential adverse reactions that are common to this immunization.
3. Discuss the potential consequences of vaccine refusal.
4. Explain that scientific studies and reviews have found no relationship between vaccines and autism.
5. Discuss the treatment of side effects and home care after immunizations.

CHN-L LITERATURE

OUTCOME: The parents/family will receive written information about child health issues.

STANDARDS:

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

CHN-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for the newborn'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.

CHN-N NUTRITION

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

STANDARDS:

1. Explain that breast milk is the healthiest feeding choice for newborns. **Refer to ["BF - Breastfeeding"](#).**
2. Explain that newborns grow appropriately on formula when breast milk is not an option. **Refer to ["FF - Formula Feeding"](#).**
3. Discuss that newborns need to be fed on demand. Nothing should be given from the bottle except breast milk, formula, or electrolyte solutions.
4. Discuss the reasons for burping newborns and methods of burping newborns.
5. Discuss that newborns have a need to suckle beyond what is necessary for nutrition. Discuss thumb sucking and pacifier use.

6. 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

OUTCOME: 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. Explain that mild jaundice is harmless but high levels of bilirubin may cause brain damage. Refer to [“NJ - Neonatal Jaundice”](#).
2. Emphasize that parents should watch closely for jaundice and seek medical attention if jaundice is noticed.
3. Explain that medical personnel can check the level of bilirubin in the blood by blood tests or occasionally by a skin test.
4. Explain that jaundice is more common in breastfed newborns especially when the infant is not nursing well. Encourage nursing the newborn 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 newborns.

CHN-PA PARENTING

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

STANDARDS:

1. Emphasize the importance of bonding and the role of touch in good emotional growth. Encourage fathers to take an active part in caring for their newborn.
2. 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.
3. Review the sleeping and crying patterns of a new baby and the importance of learning baby temperament. Crying usually peaks at 6 weeks; cuddling and rocking may console the baby. Encourage the parents to sleep when the infant sleeps.
4. 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.
5. Review the community resources (financial, medical, WIC) available for help in coping with a new baby.

CHN-S SAFETY

OUTCOME: The parents/caregiver 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. Stress the importance of carefully selecting child-care settings to ensure child safety.
2. Stress the use of a properly secured, NTBS approved, rear facing car seat EVERY TIME the newborn rides in a vehicle. **Refer to [“CHN-CAR Car Seats and Automobile Safety”](#).**
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.
4. Explain that SIDS is decreased by back or side-lying and by not smoking in the home or car. **Refer to [“SIDS-P Prevention”](#).**
5. Discuss the importance of keeping a hand on the infant when the infant is lying on any surface over floor level to avoid falls.
6. Discuss the dangers posed by hot liquids, too hot bath water, and microwaving baby bottles. (Current recommendation is to set water heater to <120°F.)

CHN-SCR SCREENING

OUTCOME: The parents/caregiver will understand the proposed screening including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed screening, e.g., phenylketonuria (PKU), hearing screening, development.
2. Explain the process and what to expect after the screening.
3. Emphasize the importance of follow-up care.

CHN-SF INTRODUCTION TO SOLID FOODS

OUTCOME: The parents/caregiver 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 infant feedings has changed, and that advice from family/friends may no longer be appropriate. Talk to the healthcare provider.
2. Explain that solid food is not appropriate for a newborn.

CHN-SHS SECOND-HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand smoke and third-hand tobacco smoke.

STANDARDS:

1. Define that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, and many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness in newborns when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia, SIDS, and lung cancer.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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-OT Quit”](#).**

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

CHI-CAR CAR SEATS AND AUTOMOBILE SAFETY

OUTCOME: The parents/caregiver will understand measures that will improve car safety.

STANDARDS:

1. Emphasize the importance that all occupants in the vehicle use appropriate safety belt or safety seat - allow no exceptions.
 - a. Stress the use of a properly secured, NTSB approved rear facing car seat EVERY TIME the infant rides in a vehicle.
 - b. Stress the importance of never using a cradle board to secure the infant in a vehicle.
 - c. The car seat should be in the middle of the back seat of the vehicle.
2. Discuss avoiding behaviors that can divert attention from driving, such as smoking, cell phone use, eating, CDs and radios, or unruly kids.
3. Emphasize the importance of never driving while under the influence of alcohol, street drugs, sedatives, or over-the-counter drugs that can cause drowsiness.
4. Discuss the need to secure or remove any loose items in the car that can fly around and hurt the baby/small child if there is a sudden stop or there is an accident.
5. Discuss the potential dangers of leaving an infant/child alone in a vehicle, e.g., vehicle gears shifted and car goes in motion, injury caused by power windows or sunroof, keys locked in vehicle with child, heat/cold exposure, abduction or child wandering away.

CHI-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The parents/caregiver will understand the impact and influences that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.
3. Discuss the dangers of prolonged exposure of the infant to ceremonial practice of burning sweet grass, sage, cedar, or tobacco.

4. Stress the importance of never using a cradle board to secure the infant in a vehicle.

CHI-ECC EARLY CHILDHOOD CARIES

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

STANDARDS:

1. Explain early childhood caries is caused when liquids containing sugar are left in a baby's mouth for long or frequent periods of time.
2. Discuss prevention of tooth decay (early childhood caries):
 - a. Avoid giving bottles when the baby is lying down. Bottle should never be propped.
 - b. Feed baby formula or breast milk PRIOR to nap or bedtime.
 - c. If baby must use a bottle to fall asleep, use a pacifier or give a bottle of plain water instead, removing it after baby goes to sleep.
 - d. Use only clean pacifiers. Never dip a pacifier in any type of sugar substance, especially honey.
 - e. Clean the baby's gums/teeth after each feeding; wipe and massage the gums/teeth with a clean wet gauze pad or cloth.
3. Explain preventive measures family members can take to avoid spreading germs that cause cavities to small children:
 - a. Review oral hygiene habits the whole family should practice.
 - b. Don't put anything in baby's mouth that has been in another person's mouth.

CHI-ECL EARLY CHILDHOOD LITERACY

OUTCOME: The parents/caregiver will understand the importance of reading aloud to children (2 months to 12 months of age).

STANDARDS:

1. Discuss that the benefits of reading aloud to children include language development, literacy skills, school readiness, and healthy coping in times of stress, and parent-child bonding.
2. Explain that reading together may promote motor and cognitive skills:
 - a. Motor skills: reaching for book, putting book in mouth, sitting in lap with head steady, turning pages with help.
 - b. Cognitive skills: Looking at pictures, vocalizing and patting pictures, preferring pictures of faces

3. Discuss what parents can do to help develop these age specific skills.
 - a. Holding child comfortably
 - b. Following baby's cues for "more" and "stop"
 - c. Pointing and naming pictures
 - d. Singing and talking to the baby

CHI-FU FOLLOW UP

OUTCOME: The parents/caregiver will understand the importance of keeping routine well child visits.

STANDARDS:

1. Emphasize the importance of follow-up care and well child visits. Discuss that well child visits are important to follow growth and development, screen for disease, and update immunizations.
2. Discuss the procedure and process for obtaining follow-up appointments and well child visit. Inform the patient/family of the timing of the next well child visit.
3. Emphasize that full participation of the treatment plan is the responsibility of the parent/caregiver.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

CHI-GD GROWTH AND DEVELOPMENT

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

STANDARDS:

1. Review the expected weight and height changes.
2. Review normal development:
 - a. improvements in neuromuscular control
 - b. improvement in visual acuity
 - c. psycho-social development—prevalence of narcissism and acquisition of trust
 - d. cognitive development—active participation with the environment fosters learning
 - e. language development, i.e., discuss the introduction of books and reading to the infant

- f. adaptive behaviors and modeling, setting an example for appropriate behavior (refer to [“CHI-PA Parenting”](#))
3. Discuss signs of teething, ages at which teething usually occurs, and the relief for teething pain.
4. Discuss bowel habits of the infant.
 - 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”](#).
 - c. Explain that toilet training should be delayed.
 - d. Explain that curiosity about genitals is normal and to be expected.
5. Discuss sleep habits and transition objects for sleep.

CHI-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding child health infant care.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding child health infant care and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

CHI-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The parents/caregiver will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices for the baby.
2. Explain healthy lifestyle choices of the parents/caregiver (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of the parents'/caregivers' healthy lifestyle on the infant.
3. Explain the need to protect the infant from illness or injury caused by exposure to:
 - a. crowds (risk of infection)
 - b. loud noises (risk hearing damage)
 - c. pets (risk of infection or injury, e.g., smothering, bites)
 - d. temperature extremes (infants can't control body temperature well)

4. Stress the dangers of fever ($>100.4^{\circ}\text{F}$) in infancy and the importance of seeking immediate medical care. Discuss that rectal temperature is a reliable method of temperature measurement in infants.
5. Discuss signs/symptoms of illness and when to seek medical care, e.g., fever $>100.4^{\circ}\text{F}$, seizure, certain rashes, irritability, lethargy, failure to eat, vomiting, diarrhea, dehydration, apnea, cyanosis.
6. Discourage use of over-the-counter medications in infancy.

CHI-HY HYGIENE

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

STANDARDS:

1. Discuss the importance of hand washing in infection prevention.
 - a. Explain the importance of hand washing especially during bottle feeding preparation and eating, diaper changing, toilet use, and anytime before caring for the infant.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Discuss the care of the circumcised and uncircumcised penis.
3. Discuss infant hygiene, e.g., bathing, avoidance of powders, skin and nail care, vaginal discharge/bleeding. Discuss appropriate diapering and diaper area skin care.
4. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.
5. Stress the importance of clean bottle, nipple, and pacifiers. **Refer to [“FF-HY Hygiene”](#).**

CHI-IM IMMUNIZATIONS

OUTCOME: The parents/caregiver will understand the immunizations necessary for preventing communicable diseases. **Refer to [“IM - Immunizations”](#).**

STANDARDS:

1. Discuss the schedule for recommended immunizations and illness they prevent.
2. Discuss the side effects and potential adverse reactions that are common to this immunization.
3. Discuss the potential consequences of vaccine refusal.

4. Explain that scientific studies and reviews have found no relationship between vaccines and autism.
5. Discuss the treatment of side effects and home care after immunizations.

CHI-L LITERATURE

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

STANDARDS:

1. Provide parents/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 the infant'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.

CHI-N NUTRITION

OUTCOME: The parents/caregiver will understand the changing nutritional needs of an infant. Discuss the following as appropriate for age.

STANDARDS:

1. Discuss the introduction of solids/supplements:
 - a. Discuss the schedule for introducing solids and juices at 4–6 months of age, and how to accomplish first spoon feeding.

- b. Explain that solids, including cereal, should not be fed from a bottle or infant feeder but from a spoon.
 - c. Discuss waiting 3–4 days between additions of new foods to identify food allergies. Serve solids 3–4 times per day.
 - d. Emphasize the importance of avoiding foods that are easy to choke on, e.g., nuts, hard candy, gum.
 - e. Emphasize the importance of having the child remain seated and observing the child while eating to reduce the risk of choking.
 - f. 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.)
 - g. Explain the dangers of giving honey before the age of one year (infantile botulism).
2. Explain that breast milk is the healthiest feeding choice for infants. **Refer to [“BF - Breastfeeding”](#)**. 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/or iron supplements when breastfeeding.
 3. Explain that infants grow appropriately on formula when breast milk is not an option. **Refer to [“FF - Formula Feeding”](#)**.
 - a. Review formula preparation and storage and proper technique and position for bottle feeding.
 - b. Emphasize the importance of bottle feeding with iron-fortified formula.
 - c. Explain that warming bottles in the microwave may result in burns to the mouth.
 - d. 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.
 - e. Discuss age appropriate intake (ounces/day), appropriate weight gain, and stress the dangers of overfeeding.

CHI-PA PARENTING

OUTCOME: The parents/caregiver will adapt in a healthy manner to the growth and development of the infant.

STANDARDS:

1. Discuss family life:
 - a. Encourage the parents to find some time to nurture their relationship.
 - b. Review basic nurturing skills: spending time with the infant, continued importance of touch, involving father in care and nurturing.

- c. 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).
 - d. Encourage fathers to take an active part in caring for the infant.
 - e. Encourage sibling participation in care of the infant while giving siblings attention as well.
2. Discuss discipline:
 - a. Techniques must be age appropriate (distraction and/or time out)
 - b. Praise good behavior
 - c. Encourage consistent parenting
 - d. Discuss the importance of limiting rules and setting routines
 - e. Do not allow hitting, biting, aggressive behavior.
 3. Discuss infant behavior:
 - a. Discuss the importance of a bedtime routine and self-consoling of baby.
 - b. Discuss comfort objects such as stuffed animals or blankets as appropriate to the age of the infant.
 - c. Discuss separation anxiety and selecting safe child care settings as appropriate.
 4. Stress importance of regular well child care and immunizations.
 5. Review the community resources available for help in coping with an infant. (WIC, social services).

CHI-S SAFETY

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

STANDARDS:

1. Explain that accidents are a major cause of death.
 - a. Emphasize the importance of learning first aid and CPR.
 - b. Review emergency procedures for home and child care.
 - c. Emphasize the importance of a properly fitting, correctly installed car seat. The placement of the car seat in the vehicle should be correct for the age/size of the infant. **Refer to [“CHI-CAR Car Seats and Automobile Safety”](#)**
2. Discuss that shaking a baby can cause permanent brain damage or death.
3. Explain that SIDS is decreased by back or side lying, by not keeping the infant too warm, and by not smoking in the home or car. **Refer to [“SIDS-P Prevention”](#).**
4. Stress that the infant’s increasing mobility requires additional vigilance and child-proof the home. **Refer to [“HPDP-S Safety”](#).**

- 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, coffee pots, irons, 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. Explain that walkers are a source of serious injury and often delay walking.
5. 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.
 6. Discuss lead hazards as appropriate. Refer to ["LEAD - Lead Exposure/Lead Toxicity"](#).

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. Discuss the recommended introduction of solid foods:
 - a. Infants should not routinely be fed foods other than breastmilk or formula prior to 6 months of age except under the advice of a healthcare provider. Emphasize

that, for some time after the introduction of solid foods, breastmilk/formula will still be the infant's primary source of nutrition.

- b. 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.
 - c. Pureed/or finely mashed vegetables and fruits should be started no earlier than 6 months of age. Emphasize the need to wait 3–5 days between the addition of new foods to watch for adverse events from the foods. New foods might be rejected but may be accepted at a later time.
2. 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.
 3. Discuss foods that should be avoided:
 - a. Highly allergenic food such as peanut butter, chocolate, eggs, cow or goat milk, and citrus should not be fed until the infant is one year of age.
 - b. Explain that honey and syrups may contain botulism toxin and should not be fed before one year of age.
 - c. Foods that are choking hazards 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.
 4. 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 and will stop when not interested. Do not force feed.
 - b. Some days babies eat a lot other days not as much.
 - c. No two babies eat the same.
 5. Explain how to assess an infant's readiness to feed:
 - a. Tongue thrusting is an indication of not being ready to eat solids.
 - b. Opens mouth when seeing food.
 - c. Closes lips over a spoon.
 - d. Keeps food in mouth instead of spitting it out.
 - e. Sits up alone without support.
 6. Explain that infant feeding recommendations have changed and that advice from family/friends may no longer be appropriate. Talk to the healthcare provider.

CHI-SHS SECOND-HAND/THIRD-HAND SMOKE

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

STANDARDS:

1. Define that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, carcinogens.
3. Explain the increased risk of illness and SIDS in infants when exposed to cigarette smoke either directly or via second-hand smoke.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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-OT Quit”](#).**

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”](#), [“OM-P Prevention”](#).**
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 parents/caregiver will understand measures that will improve car safety.

STANDARDS:

1. Stress the use of a properly fitted, properly secured, NTSB approved car seat EVERY TIME the child rides in a vehicle. The placement of the car seat in the vehicle should be correct for the age/size of the toddler.
2. Explain the dangers posed by things that might divert attention from driving, such as smoking, cell phone use, eating, CDs and radios, etc.
3. Emphasize the importance of never driving while under the influence of alcohol, sedatives, and/or street drugs.
4. Emphasize not to leave toddler/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-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The parents/caregiver will understand the impact and influences that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.
3. Discuss the dangers of prolonged exposure of the newborn to ceremonial practice of burning sweet grass, sage, cedar, or tobacco.
4. Stress the importance of never using a cradle board to secure the toddler in a vehicle.

CHT-ECC EARLY CHILDHOOD CARIES

OUTCOME: The parents/caregiver will understand the importance of good oral hygiene.

STANDARDS:

1. Discuss prevention of tooth decay (early childhood caries):
 - a. Avoid giving bottles when baby is lying down. Bottles should never be propped.
 - b. Feed baby formula or breast milk PRIOR to nap or bedtime. There should be nothing in the bottle except formula, breast milk, or electrolyte solution.
 - c. If baby must use a bottle to fall asleep, use a pacifier or give a bottle of plain water instead, removing it after baby goes to sleep.
 - d. Use only clean pacifiers; never dip a pacifier in any type of sugar substance, especially honey.
 - e. Clean baby's gums after each feeding; wipe and massage the gums with a clean wet gauze pad or cloth.
2. Review oral hygiene habits. Discuss that the whole family should practice good oral hygiene. Discuss the importance of regular dental examinations.
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.

CHT-ECL EARLY CHILDHOOD LITERACY

OUTCOME: The parents/caregiver will understand the importance of reading aloud to children (1 to 3 years of age).

STANDARDS:

1. Discuss that the benefits of reading aloud to children include language development, literacy skills, school readiness, and healthy coping in times of stress, and parent-child bonding.
2. Explain that reading together may promote motor and cognitive skills.
3. Explain age specific expectations for 12 to 18 months:
 - a. Motor skills: sitting without support, carrying book, holding book with help, turning board pages, several at a time
 - b. Cognitive skills: Pointing at pictures with one finger, making same sounds for a particular picture, pointing when asked, "where's....?", turning book right side up, giving book to adult to read
4. Discuss what parents can do to help develop these age specific skills.
 - a. Responding to child's prompting to read
 - b. Letting the child control the book
 - c. Being comfortable with toddler's short attention span

- d. Asking “Where’s the...?” and let the child point
5. Explain age specific expectations for 18 to 24 months.
 - a. Motor skills: turning board book pages easily, one at a time, carrying book around the house, using book as transitional objects (e.g., at bedtime)
 - b. Cognitive skills: naming familiar pictures, filling in words in familiar stories, “reading” to stuffed animals or dolls, reciting parts of familiar stories, attention span highly variable
6. Discuss what parents can do to help develop these age specific skills.
 - a. Relating books to child’s experiences
 - b. Using books in routines, bedtimes
 - c. Asking “What’s that?” and giving the child time to answer
 - d. Pausing and letting the child complete
7. Explain age specific expectations for 24 to 36 months.
 - a. Motor skills: Learning to handle paper pages, going back and forth in books to find favorite pictures
 - b. Cognitive skills: Reciting whole phrases, sometimes whole stories, coordinating text with picture, protesting when adult gets a word wrong in a familiar story, reading familiar books to self
8. Discuss what parents can do to help develop these age specific skills.
 - a. Keep using books in routines
 - b. Reading at bedtime
 - c. Be willing to read the same story over and over
 - d. Asking “what’s that?”
 - e. Relating books to child’s experiences
 - f. Providing crayons and paper

CHT-FU FOLLOW-UP

OUTCOME: The parents/caregiver 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 parents/caregiver 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. Discuss sleep habits and transition object for sleep. Explain that children in this age group typically sleep through the night.
3. 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.

CHT-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The parents/caregiver will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices for the baby.
2. Explain healthy lifestyle choices of the parents/caregiver (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of the parents'/caregivers' healthy lifestyle on the toddler.
3. Explain the need to protect the newborn from illness or injury caused by exposure to:
 - a. crowds (risk of infection)
 - b. loud noises (risk hearing damage)
 - c. pets (risk of infection or injury, e.g., smothering, bites)
 - d. temperature extremes (newborns can't control body temperature well)
4. Stress the dangers of fever ($>100.4^{\circ}$ F) in the newborn period and the importance of seeking immediate medical care. Discuss that rectal temperature is a reliable method of temperature measurement in toddlers. **Refer to ["NF - Neonatal Fever"](#).**
5. Discuss signs/symptoms of illness and when to seek medical care, e.g., fever $>100.4^{\circ}$ F, seizure, certain rashes, irritability, lethargy, failure to eat, vomiting,

diarrhea, jaundice, dehydration, apnea, cyanosis. Refer to [“NF - Neonatal Fever”](#).

6. Discourage use of medications in the toddler period.

CHT-HY HYGIENE

OUTCOME: The patient/family will understand hygiene issues in the toddler.

STANDARDS:

1. Discuss the importance of hand washing in infection prevention.
 - a. Explain that this hand washing can be accomplished with soap and water or alcohol-based hand cleaners.
 - b. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Discuss care of the circumcised and uncircumcised penis in boys. Discuss the need to wipe from front to back. Discuss appropriate diapering and diaper area skin care.

CHT-IM IMMUNIZATIONS

OUTCOME: The parents/caregiver will understand the immunizations necessary for preventing communicable diseases. Refer to [“IM - Immunizations”](#).

STANDARDS:

1. Discuss the schedule for recommended immunizations and illness they prevent.
2. Discuss the side effects and potential adverse reactions that are common to this immunization.
3. Discuss the potential consequences of vaccine refusal.
4. Explain that scientific studies and reviews have found no relationship between vaccines and autism.

CHT-L LITERATURE

OUTCOME: The parents/family will receive written information about child health issues.

STANDARDS:

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

CHT-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The parents/caregiver will understand the specific nutritional intervention(s) needed for the toddler'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.

CHT-N NUTRITION

OUTCOME: The parents/caregiver will understand the nutritional needs of the toddler and the frustrations that can surround mealtime.

STANDARDS:

1. Discuss feeding and meal time:
 - a. Discuss the varying levels of mastery of cups and utensils.
 - b. Emphasize that foods should never be given from a bottle or infant feeder.
 - c. Allow the toddler to self feed; finger foods are suggested.
 - d. Discuss the importance of eating meals as a family and providing 3 nutritious meals and 2-3 nutritious snacks per day.
 - e. Encourage a relaxed mealtime atmosphere.
2. Explain that toddlers growth rate is slower and the nutritional needs decrease. The recommended portion size is 1 tablespoon from each food group, per year of age. Discuss it is normal for toddlers to be fussy eaters and may eat very little for days to weeks. Continue to offer 3 nutritious meals and 2-3 nutritious snacks per day and do not offer junk food to entice the child to eat.
3. Discuss the need for whole milk up to 2 years of age and encourage low fat or non-fat milk after the age of 2 and that juice should be limited to 4-6 oz./day.

4. Avoid foods that are choking hazards through age 4 (unpeeled grapes, unpeeled apples, orange slices, nuts, popcorn, pickles, carrot sticks, celery sticks, hard candies and gum, wieners, chicken drum sticks, and peanut butter).
5. Encourage 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.
6. Explain that the recommendations regarding toddler feedings has changed and advice from family/friends may no longer be appropriate; talk to the healthcare provider.

CHT-PA PARENTING

OUTCOME: The parents/caregiver will understand challenges of parenting a toddler and will continue to provide a nurturing environment for growth and development.

STANDARDS:

1. Discuss common aspects of toddler behavior:
 - a. Continued demand much of the parent(s) time. Many toddlers still need to be held and cuddled.
 - b. Increasing mobility and autonomy increases the risk of injury and requires increased supervision.
 - c. Frequently have an unwillingness to share and frequently say “no.”
 - d. Toddlers frequently seem to have boundless energy.
 - e. Limited vocabulary often inhibits expression of emotions.
2. Discuss age appropriate disciplinary techniques:
 - a. Distraction is appropriate for some behaviors, especially in younger toddlers.
 - b. Time-out can be an effective disciplinary technique. Discuss methods of using time-out effectively.
 - c. Encourage parents/caregivers to set limits and praise good behavior.
 - d. Discuss that hitting, biting, and aggressive behaviors are common in this age group and require consistent parenting and disciplinary techniques.
3. Discuss parental needs:
 - a. Reinforce the need for adult companionship, periodic freedom from child-rearing responsibilities, and nurturing the marital relationship.
 - b. Show affection in the family.
 - c. Stress that weariness, frustration, and exasperation with a toddler are normal. Discuss mechanisms for dealing with frustration.

4. 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.
5. Discuss parental/family behaviors:
 - a. Discuss that drinking and smoking in the presence of children may promote this behavior in the child.
 - b. Discuss that children who witness violent or abusive behaviors may mimic these behaviors.

CHT-S SAFETY

OUTCOME: The parents/caregiver 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. The placement of the car seat in the vehicle should be correct for the age/size of the toddler. **Refer to [“CHT-CAR Car Seats and Automobile Safety”](#).**
3. Emphasize the importance of carefully selecting child-care settings to assure child safety. Never leave toddlers alone with young children or pets.
4. Emphasize the importance of child-proofing the home. **Refer to [“HPDP-S Safety”](#).**
 - 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, coffee pots, irons, 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-SHS SECOND-HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Define that second-hand smoke is known as "passive smoking." Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, and many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness in newborns when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia, SIDS, and lung cancer.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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-OT Quit"](#).**

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 parents/caregiver will understand measures that will improve car safety.

STANDARDS:

1. Emphasize the importance that all occupants in the vehicle use appropriate safety belt or safety seat - allow no exceptions.
 - a. Stress the use of a properly fitted, properly secured, NTSB approved car seat or booster seat EVERY TIME the child rides in a vehicle.
 - b. The placement of the car seat in the vehicle should be correct for the age/size of the child.
2. Discuss avoiding behaviors that might divert attention from driving, such as smoking, cell phone use, texting, eating, CDs and radios, or unruly kids.
3. Emphasize the importance of never driving while under the influence of alcohol, street drugs, sedatives or over-the-counter drugs that can cause drowsiness.
4. Discuss the potential dangers of leaving a child alone in a vehicle, e.g., vehicle gears shifted and car goes in motion, injury caused by power windows or sunroof, keys locked in vehicle with child, heat or cold exposure, abduction or child wandering away.

CHP-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The parents/caregiver will understand the impact and influences that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.
3. Discuss the dangers of prolonged exposure of children to ceremonial practice of burning sweet grass, sage, cedar, or tobacco.

CHP-ECC EARLY CHILDHOOD CARIES

OUTCOME: The parents/caregiver will understand the importance of good oral hygiene.

STANDARDS:

1. Discuss the importance of not using baby bottles or pacifiers at all in this age group.
2. Explain the preventive measures that family members can take to avoid spreading germs that cause cavities in small children:
 - a. Review oral hygiene habits the whole family should practice.
 - b. Don't put anything in pre-schooler's mouth that has been in another person's mouth.
3. Explain that the pre-schooler should brush at least twice daily, eat a healthy diet, and visit the dentist at least twice a year.
4. Discuss, as appropriate, fluoride supplementation and the indications for fluoridated toothpaste and when non-fluoridated tooth paste should be used.
5. Explain that dental sealants can be used to prevent cavities. The child must be old enough to sit still and keep mouth open while sealant sets up.

CHP-ECL EARLY CHILDHOOD LITERACY

OUTCOME: The parents/caregiver will understand the importance of reading aloud to children (3 years to 5 years of age).

STANDARDS:

1. Discuss that the benefits of reading aloud to children include language development, literacy skills, school readiness, and healthy coping in times of stress, and parent-child bonding.
2. Explain that reading together may promote motor and cognitive skills.
 - a. Motor skills: Competent book handling, turning paper pages one at a time
 - b. Cognitive skills: Listening to longer stories, retelling familiar stories, reading familiar books to self
3. Discuss what parents can do to help develop these age specific skills.
 - a. Asking "what's happening?"
 - b. Encouraging writing and drawing
 - c. Letting the child tell the story

CHP-FU FOLLOW UP

OUTCOME: The parents/caregiver will understand the importance of keeping routine well child visits.

STANDARDS:

1. Emphasize the importance of follow-up care and well child visits. Discuss that well child visits are important to follow growth and development, to screen for disease, and to update immunizations.
2. Discuss the procedure and process for obtaining follow-up appointments and well child visits. Inform the patient/family of the timing of the next well child visit.
3. Discuss signs/symptoms that should prompt immediate follow-up.
4. Discuss the availability of community resources and support services and refer as appropriate.

CHP-GD GROWTH AND DEVELOPMENT

OUTCOME: The parents/caregiver 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 that they are not indicative of underlying problems.
4. Review age appropriate physical growth and development.

CHP-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding child health preschool age care.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding child health preschool age care and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

CHP-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The parents/caregiver will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices for the pre-school age child.
2. Explain healthy lifestyle choices of the parents'/caregivers' (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle. Discuss the benefits of the parents'/caregivers' healthy lifestyle on the preschool age child.
3. Explain the need to protect the pre-school age child from injury by ensuring parental supervision and making environmental changes such as removing or locking up hazards (e.g. chemicals, medications), fencing the yard.
4. Stress the dangers of fever (>100.4° F) for more than three days or the fever hasn't come down with the use of medications, and the importance of seeking immediate medical care. **Refer to ["F - Fever"](#).**
5. Discuss signs/symptoms of illness and when to seek medical care, e.g., seizure, certain rashes, irritability, lethargy, fatigue, vomiting, diarrhea, dehydration, respiratory difficulty. **Refer to ["F - Fever"](#).**

CHP-HY HYGIENE

OUTCOME: The patient/family will understand hygiene issues in the preschool age child.

STANDARDS:

1. Discuss the importance of hand washing in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
 - d. Discuss teaching the preschool child personal hygiene skills such as how to properly wash hands, take a bath, brush teeth and hair, and follow proper toilet training skills.
2. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

CHP-IM IMMUNIZATIONS

OUTCOME: The parents/caregiver will understand the immunizations necessary for preventing communicable diseases. Refer to [“IM - Immunizations”](#).

STANDARDS:

1. Discuss the schedule for recommended immunizations and illness they prevent.
2. Discuss the side effects and potential adverse reactions that are common to this immunization.
3. Discuss the potential consequences of vaccine refusal.
4. Explain that scientific studies and reviews have found no relationship between vaccines and autism.
5. Discuss the treatment of side effects and home care after immunizations.

CHP-L LITERATURE

OUTCOME: The parents/caregiver will receive literature about child health issues.

STANDARDS:

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

CHP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The parents/caregiver will understand the specific nutritional intervention(s) needed for the child’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.

CHP-N NUTRITION

OUTCOME: The parents/caregiver will understand the nutritional needs of the preschooler.

STANDARDS:

1. Review the basics of a healthy meal plan. Explain that serving sizes for children are smaller than for adults. A typical serving size would be 1 tablespoon serving from each food group per year of age.
2. Encourage structured family meal times and healthy snacks between meals. Emphasize the importance of healthy snack foods, limit fatty foods and refined carbohydrates, increase fresh fruits, fresh vegetables, and fiber.
3. Discuss the relationships between childhood obesity and adult obesity. Relate the risk of diabetes to obesity. **Refer to [“OBSC - Obesity in Children \(Infancy to 18 Years\)”](#).**
4. 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 parents/caregiver will understand the transition from toddler to school age and will plan to provide a nurturing environment for this period of development.

STANDARDS:

1. Discuss age-appropriate disciplinary aspects:
 - a. Emphasize that children at this age are striving for greater independence and that in so doing they often test parental boundaries.
 - b. Discuss that increasing mobility increases the risk of injury.
 - c. Redirection is appropriate for some behaviors, especially in younger children.
 - d. Time-out can be an effective disciplinary technique. Discuss methods of using time-out effectively.
 - e. Encourage parents/caregivers to set limits and praise good behavior.
 - f. Discuss that hitting, biting, and aggressive behaviors are common in this age group and require consistent parenting and disciplinary techniques.
2. Discuss the common aspects of preschool behavior:
 - a. 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 to accept their differences. Discourage bullying and belittling behaviors.

- b. Emphasize that pre-schoolers grow at a rapid pace. Their rapidly increasing mobility and agility combined with their limited problem solving ability means that they need adult supervision.
- c. Discuss common fears of this age and the need for parental support.
- 3. Discuss the parental/family behaviors:
 - a. Discuss that drinking and smoking in the presence of children may promote this behavior in the child.
 - b. Discuss that children who witness violent or abusive behaviors may mimic these behaviors.
 - c. Discuss the need for parental discretion because the child's vocabulary is expanding. Protect children from inappropriate language not to be repeated, e.g., television, music, conversations.

CHP-S SAFETY

OUTCOME: The parents/caregiver will develop a plan for injury prevention.

STANDARDS:

- 1. Explain that with increasing independence children of this age are at risk for accidents. Continue vigilance to dangers of drowning, open flames, suffocation, poisonings, animal bites, electrocution, and motor vehicle crashes.
- 2. Emphasize the need for protective equipment, e.g., bike helmets, knee pads, elbow pads. Discourage independent operation of any motorized vehicle, including electrical vehicles.
- 3. Emphasize the need for a properly fitted, properly secured, NTSB approved car safety seat. **Refer to [“CHP-CAR Car Seats and Automobile Safety”](#).**
- 4. Emphasize the importance of carefully selecting child-care settings to ensure child safety. Discuss stranger safety and personal safety, e.g., private parts of the child's body.
- 5. Emphasize the importance of teaching the child how to safely cross the street.
- 6. Encourage participation in child identification programs. Discuss the importance of teaching the child the parent's name, complete address including state, complete telephone number including area code, and emergency phone numbers, e.g., 911.

CHP-SHS SECOND-HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Define that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, and many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia, SIDS, and lung cancer.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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 - Tobacco Use”](#).**

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

CHS-AOD ALCOHOL AND OTHER DRUGS

OUTCOME: The patient/family will understand the dangers posed by the 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. Present ways to resist peer pressure to use drugs, alcohol, and tobacco.
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 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 can 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.
3. 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 that the patient might not otherwise engage in, such as indiscriminate sex, fighting, and use of tobacco and other drugs
 - b. liver disease, up to and including complete liver failure and death

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- 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
4. Discuss resources available if the child/adolescent is currently using drugs or alcohol.

CHS-CAR CAR SEATS AND AUTOMOBILE SAFETY

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

STANDARDS:

1. Emphasize the importance that all occupants in the vehicle use appropriate safety belt or safety seat. Allow no exceptions.
 - a. Children not requiring a car seat or booster seat should be secured with a seat belt.
 - b. Children under the age of 8 or under 80 pounds should use a booster seat. Children under the age of 12 should not ride in the front seat of the car.
 - c. Ideally, the car seat or booster seat should be in the middle of the back seat of the vehicle.
2. Discuss avoiding behaviors that can divert attention from driving, such as smoking, cell phone use, texting, eating, CDs and radios, or unruly kids.
3. Emphasize the importance of never driving while under the influence of alcohol, street drugs, sedatives, or over-the-counter drugs that can cause drowsiness.
4. Discuss the need to secure or remove any loose items in the car that can fly around and hurt the child if there is a sudden stop or if in an accident.
5. Discuss the potential dangers of leaving a child alone in a vehicle, e.g., vehicle gears shifted and car goes in motion, injury caused by power windows or sunroof, keys locked in vehicle with child, heat/cold exposure, abduction or child wandering away.

CHS-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/parents/caregivers will understand the impact and influences that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.

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2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.
3. Discuss the dangers of prolonged exposure of the child to ceremonial practice of burning sweet grass, sage, cedar, or tobacco.

CHS-DC DENTAL CARE

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”](#).**
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.
 - a. 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.
 - b. Consult with an appropriate provider 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-ECL EARLY CHILDHOOD LITERACY

OUTCOME: The patient/family will understand the importance of reading aloud to children (5 years to 12 years of age).

STANDARDS:

1. Discuss that the benefits of reading aloud to children include language development, literacy skills, school readiness, and healthy coping in times of stress, and parent-child bonding.
2. Explain that reading together may promote motor and cognitive skills.
 - a. Motor skills: competent book handling, turning paper pages one at a time

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- b. Cognitive skills: Listening to longer stories, retelling familiar stories, reading familiar books to self
3. Discuss what parents can do to help develop these age specific skills.
 - a. Asking “what’s happening?”
 - b. Encouraging writing and drawing
 - c. Letting the child tell the story

CHS-EX EXERCISE

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

STANDARDS:

1. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, weight regulation, and improved self image.
2. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the child/family in developing a personal physical activity plan.
3. Discuss the appropriate frequency, intensity, time, and type of activity.
4. Refer to community resources as appropriate.

CHS-FU FOLLOW-UP

OUTCOME: The parents/caregivers will understand the importance of keeping routine well child visits.

STANDARDS:

1. Emphasize the importance of follow-up care and well child visits. Discuss that well child visits are important to follow growth and development, to screen for disease, and to update immunizations.
2. Discuss the procedure and process for obtaining follow-up appointments and well child visit. Inform the patient/family of the timing of the next well child visit.
3. Emphasize that full participation of the treatment plan is the responsibility of the parent/caregiver.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

CHS-GD GROWTH AND DEVELOPMENT

OUTCOME: The patient/parents/caregivers 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. Encourage active participation of the child in time management to get chores, school work, and play accomplished.
3. Discuss school transitions and the need to become responsible for school attendance, homework and as appropriate, course selection. Encourage participation in school activities. Encourage the identification of and pursuit of talents.
4. Discuss prepubescent/pubescent body changes and the accompanying emotions. Review the information needed to explain menses and nocturnal emissions, as appropriate. Encourage age-appropriate discussions of sexuality, abstinence, birth control, and sexually transmitted infections. **Refer to [“CHS-SX Sexuality”](#).**
5. Discuss ways to resist peer pressure.

CHS-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to child health.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.

CHS-IM IMMUNIZATIONS

OUTCOME: The patient/parents/caregiver will understand the immunizations necessary for preventing communicable diseases. **Refer to [“IM - Immunizations”](#).**

STANDARDS:

1. Discuss the schedule for recommended immunizations and illness they prevent. Explain that HPV vaccine is routinely recommended for girls 11-12 years of age and may be given to girls as young as 9 years of age and up through adulthood.
2. Discuss the side effects and potential adverse reactions that are common to this immunization.
3. Discuss the potential consequences of vaccine refusal.
4. Explain that scientific studies and reviews have found no relationship between vaccines and autism.
5. Discuss the treatment of side effects and home care after immunizations.

CHS-L LITERATURE

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

STANDARDS:

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

CHS-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for the child'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.eEvaluation of the patient's nutritional care outcomes
 - d. 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 patient/family will understand the changing nutritional needs of a school-aged child.

STANDARDS:

1. Encourage parents to model healthy eating and meal practices. Educate on healthy food choices, e.g., whole fruits, vegetables, grains, lean meat, chicken, fish, low-fat dairy products.
2. Emphasize that nutritional management includes meal planning, portion control, careful shopping, appropriate food preparation, and eating. Discuss strategies to assist the child in making healthy choices away from home (e.g., at school). **Refer to [“OBSC - Obesity in Children \(Infancy to 18 Years\)”](#).**
3. Explain the use of food label reading in selecting healthier foods.
4. Explain that six to eight small meals at frequent intervals is beneficial in reducing overeating.
5. Explain that intake of sugar-sweetened beverages increases caloric intake. Explain that adequate water intake is necessary in achieving and maintaining a healthy weight. Discuss the role of artificial sweeteners in the management of obesity in children.
6. Discuss the growth and development for appropriate age group, and the contraindications of fad diets. Refer to registered dietitian for weight management.

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. 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.
2. Discuss the importance of listening and communicating. Emphasize that school is very important to children of school age. Encourage parents to show interest in school activities.
3. 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.

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- c. Age 11–12: Increase in stormy behavior. Sexual maturation necessitates adequate and accurate sex education.
4. 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.
5. Discuss that the preteen needs affection and praise for good behavior. 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.
6. Discuss the influence of parental/family behaviors:
 - a. Discuss that drinking and smoking in the presence of children may promote this behavior in the child.
 - b. Discuss that children who witness violent or abusive behaviors may mimic these behaviors.
 - c. Emphasize the importance of modeling respect, family values, safe driving practices, and healthy behaviors.

CHS-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.

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3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

CHS-S SAFETY

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. The placement of the car seat/booster in the vehicle should be correct for the age/size of the child. Review traffic safety. **Refer to [“CHS-CAR Car Seats and Automobile Safety”](#).**
2. Review personal safety - approaches by strangers, sexual molestation, chat rooms, sex-texting, bullying, self strangulation (choking game), etc. Discuss home safety rules.
3. Discuss age-appropriate recreational activities. (Most children in this age group lack the coordination to operate a motor vehicle safely.)
4. Discuss the appropriate use of personal protective equipment when engaging in sports, e.g., helmets, knee and elbow pads; life vests; and protective body gear.
5. Discuss learning to swim to reduce the risk of drowning death and never using drugs or alcohol while swimming.
6. Encourage gun safety programs. Discuss safe storage of guns e.g., gun safes/gun locks or removing guns from the home as appropriate.

CHS-SHS SECOND-HAND/THIRD-HAND SMOKE

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

STANDARDS:

1. Define that second hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke:, e.g., nicotine, benzene, carbon monoxide, lead, carcinogens.
3. Explain the increased risk of illness in children when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia, SIDS, and lung cancer.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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-OT Quit”](#).**

CHS-SOC SOCIAL HEALTH

OUTCOME: The patient/family will understand factors in developing social competence.

STANDARDS:

1. Encourage the pre-teen to recognize and learn about the personal strengths and engage in activities to build upon these. Encourage taking on new challenges to build confidence.
2. Discuss coping mechanisms:
 - a. 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.
 - b. Discuss mechanisms to recognize and deal with stress. Learn to recognize self-destructive behaviors and to seek help for feelings of hopelessness.
 - c. Discuss the influence of peer pressure and mechanisms for resisting negative peer pressure.
 - d. Discuss the importance of respecting the rights of others.
 - e. Discuss the importance of listening and communicating.
 - f. Discuss increased independence in decision making, and taking on new responsibilities.
3. As appropriate discuss athletic conditioning.
4. Discuss physical/emotional health:

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- a. sleep about 8 hours per night
 - b. engage in physical activity at least 60 minutes/day
 - c. drink plenty of fluids (especially water)
 - d. maintain a healthy weight
 - e. avoid loud music
 - f. avoid street drugs, tobacco, and alcohol
5. 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, social, and community activities
 - d. sports and exercise
 - e. physical/emotional health

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.
 - a. Discuss that this is happening at a earlier age and may produce an expectation of a more mature behavior which is often unrealistic and can lead to self esteem issues.
 - b. 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"](#).**
 - c. Explain that as a general rule, menarche occurs within two years of thelarche (breast development). (Discuss as appropriate)
 - d. Discuss menses and nocturnal emissions as appropriate.
3. Discuss the elements of a positive, nurturing interpersonal relationship versus a potentially abusive relationship. Identify the community resources available for sexuality counseling.
4. Review the physical and emotional benefits of and encourage abstinence (e.g., self-respect, negating the risk of STIs and pregnancy, dramatically reducing the

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risk of cervical cancer, having the first sexual encounter be in the context of a stable, loving relationship).

- a. Explain that it is normal to have sexual feelings but that having sex should be delayed.
 - b. Detail some ways that the preteen could say “no” to having sex.
 - c. Discuss abstinence, contraception, and safer sex (including correct use of latex condoms) if sexually active.
5. As appropriate, discuss any concerns about feelings for persons of the same or opposite sex.

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. Discuss the common problems associated with nicotine addiction and the long term effects of continued use of tobacco, e.g., COPD, cardiovascular disease, numerous kinds of cancers including lung cancer.
3. Review the effects of tobacco use on all family members: financial burden, second-hand smoke, greater risk of fire and premature death.
4. If the patient is already using tobacco, encourage tobacco cessation and refer to cessation program or behavioral health provider. **Refer to [“TO - Tobacco Use”](#).**

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 use 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. These drugs also 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.

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- 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 many 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-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components as it relates to adolescence.

STANDARDS:

1. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common during adolescence, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
2. Discuss mechanisms to recognize and deal with stress. Learn to recognize destructive or aggressive thoughts and behaviors, self injurious behavior, feelings of hopelessness, and how to seek help.
3. Discuss how body image and feelings of self worth are related.
4. Discuss that peer pressure can predispose to risky behaviors and altered body image.
5. Discuss the potential of dangers of self-medication with tobacco, alcohol, or other drugs. Refer to [**“AOD - Alcohol and Other Drugs”**](#).
6. Refer to a mental health agency or provider as indicated.

CHA-CAR AUTOMOBILE SAFETY

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

PATIENT EDUCATION PROTOCOLS:**CHILD HEALTH ADOLESCENT (12-18 YEARS)**

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. Discuss car seats as appropriate.
3. Explain the dangers posed by things that might divert attention from driving, such as smoking, cell phone use, texting, eating, CDs and radios, unruly passengers, 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-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.
3. Discuss the dangers of prolonged exposure of the adolescent to the ceremonial practice of burning sweet grass, sage, cedar, or tobacco.

CHA-DC DENTAL CARE

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 frequent carbohydrate consumption increases the rate of acid attacks, thereby increasing the risk of dental decay. **Refer to ["DC-N Nutrition"](#).**

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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 an appropriate provider 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-EX EXERCISE

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

STANDARDS:

1. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, weight regulation, and improved self image.
2. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the adolescent in developing a personal physical activity plan.
3. Discuss the appropriate frequency, intensity, time, and type of activity.
4. Refer to community resources as appropriate.

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.

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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. Encourage identification and pursuit of talents.
4. Encourage active participation of the child in time management to get chores, school work, and play accomplished.
5. Review the increasing importance of hygiene.
6. Discuss prepubescent/pubescent body changes and the accompanying emotions:
 - a. Review the information needed to explain menses and nocturnal emissions, as appropriate. **Refer to [“CHA-MS Menses”](#),**
 - b. 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.
 - c. Explain that puberty and the associated growth spurt begins and ends at an earlier age in girls than in boys.

CHA-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary

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4. Review the community resources available for help in achieving behavior changes.

CHA-HY HYGIENE

OUTCOME: The patient will understand personal routine hygiene as it relates to adolescence.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, and toilet use.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
2. Review the importance of bathing, paying special attention to face, pubic hair area, armpits, and feet. Suggest that deodorants may be necessary to control body odor at this age. Discuss hygiene as part of a positive self image. **Refer to [“ACNE - Acne”](#).**
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.

CHA-L LITERATURE

OUTCOME: The parents/family will receive literature about adolescent health issues.

STANDARDS:

1. Provide the parents/family with literature on adolescent health issues.
2. Discuss the content of the literature.

CHA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for the adolescent'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

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- 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-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.
5. Discuss the non-contraceptive use of oral contraceptives to regulate menses.

CHA-N NUTRITION

OUTCOME: The parent(s)/family and adolescent will relate nutrition to growth and development.

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. 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. **Refer to ["HPDP-N Nutrition"](#).**
2. Review the basics of a nutritious meal plan. Teach the teen to make healthy food choices. Emphasize the role peers play in food intake and ways to resist negative peer pressure. Encourage three nutritious meals a day and healthy snacks.
3. Encourage parents to model healthy nutritional habits and to eat as a family as often as possible. Encourage parents/teens to read food and beverage labels and then make healthy choices, e.g., whole fruits, vegetables, grains, lean meat, chicken, fish, low-fat dairy products. Refer to a registered dietitian or other appropriate resource.

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4. Emphasize that large portions of sweetened drinks have no nutritional value and increase the risk for obesity. **Refer to [“OBSC - Obesity in Children \(Infancy to 18 Years\)”](#).**
5. Encourage maintenance of a healthy weight with good nutrition and physical activity. Discuss the warning signs and risks of anorexia and bulimia in adolescence. Refer to a registered dietitian. **Refer to [“EAT - Eating Disorders”](#).**
6. Emphasize the importance of not skipping meals, especially breakfast.

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. Explain the importance of teaching adolescents to respect others and accept their differences. Discourage bullying and belittling behaviors.
2. Discuss the parent/teen relationship:
 - a. Stress the importance of communicating (especially LISTENING) and providing a supportive environment.
 - b. Discuss the importance of spending quality time with the teenager.
 - c. Emphasize that teens need praise for good behavior.
 - d. Discuss the importance of establishing realistic expectations, clear limits, and consequences.
 - e. Discuss that the parent/teen relationship will likely be better if the parent minimizes criticism, nagging and negative messages.
 - f. Emphasize the importance of consistency in parenting.
 - g. Discuss the importance of respecting the teen’s need for privacy.
 - h. Provide an environment that allows for increased independence and decision-making.
 - i. Emphasize the importance of knowing the child’s friends and their families.
 - j. Discuss monitoring for alcohol, drug, and tobacco use as well as sexual activity.
 - k. Discuss the destructiveness of parent/teen violence. **Refer to [“BH - Behavioral and Social Health”](#).**
3. Emphasize that school activities are often very important to teenagers. Encourage parents to show interest in school activities.

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4. Discuss how fluctuating hormone levels affect emotions. Be alert for significant changes in behavior which may indicate psychosocial stressors or negative peer influences.
5. Discuss the parent/family behaviors:
 - a. Discuss that drinking and smoking in the presence of children/teens may promote this behavior in the child.
 - b. Discuss that children/teens who witness violent or abusive behaviors may mimic these behaviors.
 - c. Emphasize the importance of modeling respect, family values, safe driving practices, and healthy behaviors.
 - d. Discuss that guns should be handled responsibly. Encourage gun safes/gun locks or removing guns from the home as appropriate.

CHA-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status

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- b. maternal age
- c. lifestyle changes
- d. employment
- e. number and spacing of pregnancies
- f. childcare
- g. Refer for medical and psychosocial support services for any risk factor identified.

CHA-S SAFETY

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

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. Promote driving education courses and the importance of following the speed limit and other rules of the road. **Refer to [“CHA-CAR Automobile Safety”](#).**
2. Promote the safe use of all recreational vehicles (e.g., all terrain vehicles (ATVs), snow machines, boats, horses), discuss personal protective equipment, e.g., helmets, knee pads, elbow pads, mouth guards. Refer to community resources as appropriate.
3. Discuss learning to swim to reduce the risk of drowning death and never using drugs or alcohol while swimming.
4. 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”](#).**
5. Review personal safety strategies to prevent incidents, e.g., sexual molestation, date rape, choice of apparel, sex-texting, cyber-bullying, strangers, chat rooms, self strangulation (Choke Game), etc. Discuss home safety rules.
6. Review self-destructive behaviors (negative peer pressures, suicidal gestures and comments, improper/inappropriate use of firearms, gangs, cults, hazing, alcohol and substance use/abuse). **Refer to [“BH - Behavioral and Social Health”](#).**

CHA-SHS SECOND-HAND/THIRD-HAND SMOKE

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

STANDARDS:

1. Define that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand

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smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.

2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, carcinogens.
3. Explain the increased risk of illness in children when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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-OT Quit"](#).**

CHA-SOC SOCIAL HEALTH

OUTCOME: The patient/family and adolescent will understand factors in developing social competence.

STANDARDS:

1. Encourage the teen to recognize and learn about personal strengths and engage in activities to build upon these. Encourage taking on new challenges to build confidence.
2. Discuss coping mechanisms:
 - a. Discuss the importance of a mentor or trusted adult with which to discuss feelings and ideas. This is especially true if things do not seem to be going well
 - b. Discuss mechanisms to recognize and deal with stress. Learn to recognize self-destructive behaviors and to seek help for feelings of hopelessness. Refer to Social Services.
 - c. Discuss the influence of peer pressure and mechanisms for resisting negative peer pressure.
 - d. Discuss the importance of respecting the rights of others.
 - e. Discuss the importance of listening and communicating.
3. Discuss increased independence in decision making and taking on new responsibilities.
4. As appropriate discuss athletic conditioning.
5. Discuss physical/emotional health:
 - a. sleep about 8 hours per night.
 - b. engage in physical activity 30-60 min. 3+ times per week

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- c. drink plenty of fluids (especially water).
- d. maintain a healthy weight
- e. avoid loud music
- 6. 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, social, and community activities
 - d. sports and exercise

CHA-SM STRESS MANAGEMENT

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

STANDARDS:

- 1. Explain that unmanaged stress can have an adverse effect.
- 2. Explain the role of effective stress management in adolescence.
- 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.

CHA-SX SEXUALITY

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

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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 infections.
2. Explain the physical changes that result from increased hormonal activity.
 - a. Discuss that this is happening at an earlier age and may produce an expectation of a more mature behavior which is often unrealistic and can lead to self esteem issues.
 - b. 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”](#).**
 - c. Explain that as a general rule, menarche occurs within two years of thelarche (breast development). (Discuss as appropriate.)
 - d. Discuss menses and nocturnal emissions as appropriate.
3. Discuss the elements of a positive, nurturing interpersonal relationship versus a potentially abusive relationship. Identify the community resources available for sexuality counseling.
4. 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).
 - a. Explain that it is normal to have sexual feelings but that having sex should be delayed.
 - b. Detail some ways that the teen could say “no” to having sex.
5. Discuss abstinence, contraception, and safer sex (including correct use of latex condoms) if sexually active. Identify community resources available for teenage sexuality counseling. **Refer to [“FP - Family Planning”](#).**
6. As appropriate, discuss any concerns about feelings for persons of the same or opposite sex.

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.

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2. 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.
3. Review the effects of tobacco use on all family members: financial burden, second-hand smoke, greater risk of fire and premature death.
4. 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"](#).**

CB - Childbirth

CB-ADV **ADVANCE DIRECTIVE**

OUTCOME: The patient/family 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 many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is able to provide guidance at the time that decisions need to be made.
3. Explain that the Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences of care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.

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-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components as it relates to childbirth.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of childbearing as a life-altering illness that requires a change in lifestyle (refer to [“PP-LA Lifestyle Adaptations](#), [“PDEP-HPDP Health Promotion, Disease Prevention](#), [“CHN-PA Parenting](#)).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in childbearing, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. Refer to [“AOD - Alcohol and Other Drugs](#).
6. Refer to a mental health agency or provider.

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 that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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 follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding child birth.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding child birth and dealing with issues.
2. Provide the help line phone number or Internet address (URL), such as <http://www.nlm.nih.gov/medlineplus/childbirth.html>

CB-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to childbirth.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

CB-ISEC INFANT SECURITY

OUTCOME: The patient/family will have basic understand of necessary infant security measures.

STANDARDS:

1. Explain the infant security measures that have been implemented to decrease the chances of infant abduction from this facility.
2. Explain the role and responsibilities parents and visitors have for maintaining infant security.

CB-L LITERATURE

OUTCOME: The patient/delivery partner/coach will receive literature about childbirth.

STANDARDS:

1. Provide the 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](#).
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 (refer to [“CHN-NJ Neonatal 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. Explain that mild jaundice is harmless but high levels of bilirubin may cause brain damage.
2. Explain that 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.
3. Emphasize that parents should watch closely for jaundice and seek medical attention if jaundice is noticed.

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 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.
6. 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.
4. Discuss epidural vs. general anesthesia for C-section.

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.
3. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review

- e. Measures to prevent surgical site infections

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](#), [“PP - Postpartum](#).

CB-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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 are many reasons why a woman may want to consider trial of labor after cesarean section. Compared with a planned cesarean delivery, a VBAC

after successful trial of labor after cesarean section is associated with the following benefits:

- a. No abdominal surgery
- b. Shorter recovery period
- c. Lower risk of infection
- d. Less blood loss

For women planning to have more children, VBAC may help them avoid problems linked to multiple cesarean deliveries. These problems include hysterectomy, bowel or bladder injury, and certain problems with the placenta.

2. Explain that although it is not possible to predict whether trial of labor after cesarean section and VBAC will be successful, several factors have been shown to increase or decrease the likelihood of success:
 - a. There is higher success rate of VBAC among women who have had a prior vaginal delivery.
 - b. The success rate for VBAC is decreased if there is a need to induce labor (use drugs or other means to bring on labor).
 - c. If the previous cesarean delivery was done for a condition that is likely to recur, such as a slowed or stopped labor, Trial of labor after cesarean section and VBAC are less likely to be successful than if the previous cesarean delivery was done for a condition that is not likely to recur, such as a breech presentation.
 - d. Other factors that may decrease the chance of a successful trial of labor after cesarean section and VBAC include:
 - i. Increased age of the mother
 - ii. High birth weight of the baby
 - iii. High body mass index of the mother
 - iv. Pregnancy beyond 40 weeks of gestation
 - v. Preeclampsia
 - vi. Short time between pregnancies
3. Explain the importance of having prior medical records to determine whether the patient is a candidate for VBAC.
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-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family/caregiver will understand the process of developing an advance directive and its role in guiding medical care and decision making to best serve the patient's care preferences.

STANDARDS:

1. Explain that many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is unable to provide guidance at the time that decisions need to be made.
3. Explain that Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences for care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer,) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.
6. Refer to [“ADV - Advance Directives](#).

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 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 which (a) regulates blood pressure, (b) stimulates the bone marrow to produce red blood cells, and (c) stimulates absorption of calcium by the intestine and bone.

CKD-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to CKD.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with CKD as a life-altering illness that requires a change in lifestyle (**refer to [“CKD-LA Lifestyle Adaptations](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with CKD, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#)**.
6. Refer to a mental health agency or provider.

CKD-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications/symptoms of untreated or progressive kidney disease.

STANDARDS:

1. Explain that CKD is progressive in nature. Explain how CKD increases the risk for heart/cardiovascular disease.
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 malnutrition can result from inadequate caloric and protein intake due to loss of appetite or uremia.
4. Explain how bone disease develops from a consequence of phosphorus retention and calcitriol deficiency leading to secondary hyperparathyroidism.

5. Explain that as the kidney function decreases, functional status (e.g., quality of life) may decrease and well-being may be affected. 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. 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.
6. 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.

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”](#).**

CKD-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

CKD-DIA DIALYSIS

OUTCOME: The patient/family will understand the process, risks, and benefits of dialysis and events that may result from refusal of dialysis.

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. **Refer to [“DIA - Dialysis](#).**
2. Explain the different types of dialysis **Refer to [“DIA - Dialysis](#).**
3. Explain that the patient should avoid blood draws and IVs on the arm to protect blood vessels for potential dialysis access (fistula).
4. Discuss the expected patient/family involvement in the care required following dialysis.

CKD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the patient’s specific type of chronic kidney disease (CKD).

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 - Refer to [“DIA - Dialysis](#)**CKD-FU FOLLOW-UP**

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

CKD-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding chronic kidney disease.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding chronic kidney disease and dealing with issues.
2. Provide the help line phone number or Internet address (URL), such as <http://kidney.niddk.nih.gov/KUDiseases/pubs/choosingtreatment/index.aspx>

CKD-L LITERATURE

OUTCOME: The patient/family will receive literature about chronic kidney disease.

STANDARDS:

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

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 and may change over time. 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. Review the community resources available to assist the patient in making lifestyle changes and make referrals as appropriate.
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. 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.

6. 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, as it pertains to 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 and help reduce phosphate levels.
5. Explain the importance of notifying the healthcare team about chronic kidney disease since some medication doses must be adjusted.
6. Emphasize the importance of bringing all medications to medical appointments.

CKD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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. Explain the importance of maintaining regular appointments with a Registered Dietitian for ongoing medical nutrition therapy.
2. Discuss that the dietary regimen will change as laboratory values and other indices change in conjunction with disease progression and treatment.
3. Discuss the nutritional modifications for end stage kidney disease as appropriate. Typical dietary restriction may include fluids, protein types, potassium, sodium, and phosphorus.
4. Explain that lack of appetite for red meats, fish, poultry, eggs, or other protein foods is common. Work with patient to plan adequate protein and calorie intake.
5. Discuss current nutritional habits. Assist the patient in identifying unhealthy eating behaviors that could interfere with the nutritional plan. Provide information about dining away from home or home delivered meals.

CKD-P PREVENTION

OUTCOME: The patient/family will understand how to prevent or slow progression of chronic kidney disease (CKD).

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. Discuss screening family members who are at high risk for chronic kidney disease.

CKD-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how childbearing affects the health of the patient with chronic kidney disease.
2. Discuss how health and lifestyle factors influence reproductive health and childbearing:

- a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
3. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health, CKD) during preconception and pregnancy in planning to reduce risk of birth defects and complications
 4. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
 5. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
 6. Refer for medical and psychosocial support services for any risk factor identified.

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).

4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

CKD-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. **Refer to [“AF-REF Referral Process.”](#)**
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

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. Discuss that even with proper dialysis, patients may experience fluid imbalances; shortness of breath, unusual swelling, dizziness, etc. and should prompt medical evaluation. Refer to [“DIA-TX Treatment](#).
- a. Hemodialysis
- b. Peritoneal dialysis
5. Discuss Kidney transplant as a treatment option:
 - a. Kidney transplantation is completed in end stage kidney disease when the glomerular filtration rate drops to 10 mL/min.
 - b. Persons older than 50 years of age with poor health or history of cancer often can not receive a transplant.
 - c. Children must receive an evaluation from a pediatric renal transplant team prior to receiving a transplant or being considered as a donor.
 - d. After a renal transplant, the patient has a functioning donor kidney. Medications and regular medical evaluations will usually be required to prevent rejection.
 - e. 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.
 - f. Patients with co-morbidities leading to initial kidney failure must be instructed to follow all prescribed regimens to avoid subsequent kidney failure.
 - g. There is a possibility that a donor kidney may fail or be rejected even under ideal conditions.
6. Review with the patient/family the risks and benefits of each renal replacement therapy option and the consequences of refusing treatment.

COPD - Chronic Obstructive Pulmonary Disease

COPD-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family 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 many persons are not able 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"](#).

COPD-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to chronic obstructive pulmonary disease.

STANDARDS:

1. Explain the normal anatomy and physiology of the respiratory system.
2. Discuss changes to anatomy and physiology as a result of COPD. There are two main forms of COPD, but most people with COPD have a combination of both conditions.
 - a. Chronic bronchitis, defined by a long-term cough with mucus
 - b. Emphysema, defined by destruction of the lungs over time
3. Discuss the impact of these changes on the patient's health or well-being.

COPD-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to chronic obstructive pulmonary disease.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with COPD as a life-altering illness that requires a change in lifestyle (**refer to ["COPD-LA Lifestyle Adaptations"](#)**).

PATIENT EDUCATION PROTOCOLS:**CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with COPD, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#).**
6. Refer to a mental health agency or provider.

COPD-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of chronic obstructive pulmonary disease.

STANDARDS:

1. Discuss that the most common complications of COPD are difficulty breathing or infection. Other complications may include arrhythmias, heart failure, pneumothorax, or severe weight loss and malnutrition.
2. Emphasize early medical intervention for minor URIs, fever, or a rapid increase in shortness of breath.

COPD-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”](#).**

COPD-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 health and wellness.

PATIENT EDUCATION PROTOCOLS:**CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective. Refer to [“COPD-TO Tobacco \(Smoking\)”](#) and [“COPD-SHS Second-Hand/Third-Hand Smoke”](#).

COPD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the etiology and pathophysiology of chronic obstructive pulmonary disease.

STANDARDS:

1. Review the anatomy and physiology of the respiratory system.
2. Discuss how the symptoms of COPD develop slowly over time and some people may not even be aware they are sick. Symptoms include: cough with mucus, shortness of breath, fatigue, frequent respiratory infections, and wheezing.
3. Discuss how COPD affects the ability of the respiratory system to exchange O₂/CO₂ and resist infection.
4. Discuss the pathophysiology of the patient’s specific disease process. COPD has two main forms, chronic bronchitis and emphysema, which can exist separately or in combination.
5. Explain that COPD is a chronic illness. The disease will get worse much more quickly if one continues to smoke.

COPD-EQ EQUIPMENT

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

STANDARDS:

1. Discuss considerations specific to equipment and understand their role in the management of COPD:
 - a. Bilevel (or continuous) positive airway pressure ventilation:
 - i. BiPAP or CPAP is delivered utilizing a tight-fitting mask over the nose and/or mouth. Improper fit can cause skin breakdown.

PATIENT EDUCATION PROTOCOLS:**CHRONIC OBSTRUCTIVE PULMONARY DISEASE**

- ii. Patient cooperation is vital to successful BiPAP or CPAP management. Some machines contain memory chips that monitor use and effectiveness.
 - b. Nebulizer: Describe proper use of the nebulizer including preparation of the inhalation mixture, inhalation technique, and care of equipment. Discuss the nebulizer treatment as it relates to the medication regimen. **Refer to [“M-NEB Nebulizer”](#).**
 - c. Oxygen:
 - i. Discuss the how a regular monitoring schedule can help determine when emergency care is needed, prevent exacerbations through early intervention, and facilitate management of the COPD.
 - ii. Emphasize that O2 flow rate should not be changed except upon the order of a physician because altering the flow rate may worsen the condition.
 - iii. Emphasize the importance of keeping the oxygen away from flames and not smoking while oxygen is flowing.
2. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
3. Demonstrate and participate in the return demonstration of the safe and proper use, care, and cleaning of the equipment 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. Create a backup plan for electrical equipment in the event of a power outage.

COPD-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.

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2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan. Patients with severe COPD will be short of breath with most activities.
4. Encourage the patient to increase the intensity and duration of the activity as the patient becomes more fit.
5. Refer to pulmonary rehabilitation or community resources as appropriate. Pulmonary rehabilitation can help maintain strength in the legs so less demand is placed on the lungs when walking. It can also be used to teach breathing in a different way so the patient can stay active.

COPD-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

COPD-HM HOME MANAGEMENT

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

STANDARDS:

1. Discuss the home management plan and the methods for implementation of the plan. Things to do include:
 - a. Avoiding very cold air
 - b. Making sure no one smokes in your home
 - c. Reducing exposure to air pollution and other irritants, such as:
 - i. Wood-burning fireplaces (ensure at least adequate ventilation)
 - ii. Cleaning or replacing the flue and chimney
 - iii. Avoidance of kerosene heaters

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- iv. Replacing filters as recommended
- v. Spray or aerosol products
2. Identify and avoid/remove 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.
3. Discuss occupational and craft exposures that might occur in the home. These include exposure to certain gases, fumes or cooking gas without proper ventilation.
4. Explain the importance of following a home management plan, e.g., fewer emergency room visits and fewer hospitalizations.

COPD-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to chronic obstructive pulmonary disease.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

COPD-IS INCENTIVE SPIROMETRY

OUTCOME: The patient/family 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.

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2. Explain that the optimal body position for incentive spirometry is semi-Fowler's position (head is elevated 30 to 45 degrees) which allows for free movement of the diaphragm.
3. Instruct the patient to exhale normally and evenly and 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.

COPD-L LITERATURE

OUTCOME: The patient/family will receive literature about chronic obstructive pulmonary disease.

STANDARDS:

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

COPD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary to prevent complications of chronic obstructive pulmonary disease and prolong life.

STANDARDS:

1. Discuss lifestyle changes which the patient has the ability to make, such as: cessation of smoking, dietary modifications, weight control, participation in treatment and exercise.
2. Re-emphasize how complications of COPD 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.

COPD-M MEDICATIONS

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

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STANDARDS:

1. Discuss the difference between bronchodilators and anti-inflammatory medications, and between short-acting relief and long-acting controller medications. Refer to ["COPD-MDI Metered-Dose Inhalers"](#) or ["M-MDI Metered-Dose Inhalers"](#).
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 the difference between bronchodilator and anti-inflammatory (e.g., short acting relieve and long acting controller) medications.
5. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
6. 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.

COPD-MDI METERED-DOSE INHALERS

OUTCOME: The patient/family will demonstrate the correct technique for use of MDIs and understand their role in the management of chronic obstructive 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.
3. Discuss the purpose of a spacer device. Instruct and demonstrate proper technique for spacer use. Discuss the proper care and cleaning of spacers.

COPD-MNT MEDICAL NUTRITION THERAPY

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

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- 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.

COPD-N NUTRITION

OUTCOME: The patient/family will understand how to modify diet to conserve energy and promote nutritional balance.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake. Stress the importance of water intake to aid in thinning sputum.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to dietitian for MNT as appropriate.

COPD-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of developing chronic obstructive pulmonary disease or complications.

STANDARDS:

1. Discuss the role of tobacco and the need to avoid it. Continued smoking is the leading cause of COPD complications and disease progression. **Refer to ["TO - Tobacco Use"](#).**
2. Discuss avoiding exposures to heavy amounts of secondhand smoke and pollution.
3. Discuss occupational and craft exposures. These include exposure to certain gases, fumes or cooking gas without proper ventilation.
4. Explain the importance of vaccinations, especially against Pneumococcus and Influenza, particularly in patients who already have COPD. **Refer to ["IM - Immunizations"](#) and ["FLU - Influenza"](#).**

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COPD-PRO PROCEDURE

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. Discuss the indications, risks, and 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. **Refer to [“COPD-TX Treatment”](#).**
2. Explain the process and what is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

COPD-SHS SECOND-HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Explain that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, and many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness when exposed to tobacco smoke either directly or via second-hand/third-hand smoke.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-hand smoke.

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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-OT Quit"](#).**

COPD-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results
3. Discuss common tests including: spirometry, X rays, CT scans, and arterial blood gas tests.

COPD-TO TOBACCO (SMOKING)

OUTCOME: The patient/family will be aware of the dangers of smoking or exposure of the patient to cigarette smoke and will develop a plan to eliminate exposure.

STANDARDS:

1. Explain the increased risk of illness in the COPD 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. Develop a quit plan if the patient is ready to make a quit attempt.

5. Refer to [“TO - Tobacco Use”](#).

COPD-TX TREATMENT

OUTCOME: The patient/family will understand the treatment plan for chronic obstructive pulmonary disease.

STANDARDS:

1. Develop a quit plan for tobacco, if patient is ready to make a quit attempt. Quitting smoking is the best way to slow down lung damage.
2. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation with treatment plan.
3. Discuss specific therapies that may be utilized, their own inherent risks, side effects, and expected benefits:
 - a. BiPAP or CPAP - Refer to [“COPD-EQ Equipment”](#)
 - b. Nebulizer - Refer to [“COPD-EQ Equipment”](#)
 - c. Oxygen
 - d. Intubation
 - e. Mechanical ventilation
 - f. Tracheostomy
4. Explain the criteria for discontinuing certain therapies, e.g. mechanical ventilation.
5. Discuss the importance of maintaining a positive mental attitude.

CPM - Chronic Pain

CPM-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

CPM-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to chronic pain.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with chronic pain as a life-altering illness that requires a change in lifestyle (**refer to [“CPM-LA Lifestyle Adaptations”](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with chronic pain, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#)**.
6. Refer to a mental health agency or provider.

CPM-CM CASE MANAGEMENT

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

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”](#).**

CPM-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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.
2. Assess the level of pain. Emphasize that the goal of treatment is to relieve pain. Reassess as needed.
3. Review lifestyle factors which may worsen or aggravate the condition.
4. Discuss the patient’s specific condition, including anatomy and pathophysiology as appropriate.
5. 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 understand and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
 - g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

CPM-EX EXERCISE

OUTCOME: The patient 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 physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

CPM-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.

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.

CMP-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

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 the patient's specific pain.

STANDARDS:

1. Provide the patient/family with literature on the patient's specific 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. Discuss lifestyle adaptations specific the patient's specific disorder.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
 - a. Discuss the use of heat and cold as appropriate
 - b. Emphasize the importance of rest and avoidance of fatigue
4. Refer to community services, resources, or support groups, as available.

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. 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

CPM-MNT MEDICAL NUTRITION THERAPY

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

CPM-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to chronic pain management.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of weight control.
4. Discuss the importance of regular meals and adequate fluid intake.
5. Explain that oral supplements are beneficial if oral intake is less than optimal.
6. Refer to registered dietitian for MNT or other local resources as appropriate.

CPM-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of developing or the worsening of chronic pain.

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, such as stretching and warm up before exercise, lifting techniques, proper ergonomics.

CPM-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient; and may be multifaceted.
3. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

CPM-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of chronic pain management.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

CPM-S SAFETY

OUTCOME: The patient will understand the importance of safety as it relates to chronic pain management.

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.
4. Discuss safety of family/patient while operating motor vehicles/heavy equipment while on pain medications.

CPM-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress can have adverse effects, may exacerbate the symptoms, and may interfere with the treatment of chronic pain.
2. Discuss that in chronic pain, uncontrolled stress may lead to depression or other mood disorders. **Refer to [“CPM-PSY Psychotherapy”](#).**
3. Explain the role of effective stress management in chronic pain.
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 pain.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle and provide referrals as appropriate. Examples of stress management strategies 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, 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.

CPM-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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 treatments that may be utilized:
 - a. 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.
 - b. Discuss with the patient/family the possible appropriate procedural or operative pain management techniques, e.g., nerve block, intrathecal narcotics, local anesthesia.
 - c. Discuss with the patient/family the possible appropriate pharmacologic pain relief measures. **Refer to [“CPM-M Medications”](#).**
2. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation in the treatment plan.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.

4. Discuss the importance of maintaining a positive mental attitude.
5. As appropriate, discuss the implications of patient-provider contracts for pain medications.

COG - Cognitive Disorders NOS

COG-ADL ACTIVITIES OF DAILY LIVING

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

STANDARDS:

1. Discuss the importance of supervising the patient's 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), or learning to assume responsibility of ADLs on behalf of the patient.
2. Assist the 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.

COG-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology of the brain as it relates to the cognitive dysfunctions.

STANDARDS:

1. Explain the normal anatomy and physiology of the brain, and how it relates to behavior.
2. Discuss changes to anatomy and physiology as a result of physical trauma or disorder.
3. Discuss the impact of these changes on the patient's health or well-being.

COG-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components as it relates to cognitive disorders.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with cognitive disorder as a life-altering illness that requires a change in lifestyle (refer to ["COG-LA Lifestyle Adaptations"](#)).
2. Discuss the potential stress, and other emotional reactions that are common in coping with a cognitive disorder, and the danger of further complications or mental health diagnoses related to it.

3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#).**
6. Refer to a mental health agency or provider.

COG-C COMPLICATIONS

OUTCOME: The family will understand the potential complications of cognitive disorders.

STANDARDS:

1. Explain that individuals with cognitive may often develop comorbid conditions, such as depression (**refer to [“DEP - Depressive Disorders”](#)**), delirium, (**refer to [“DEL - Delirium”](#)**), suicidal behavior (**refer to [“SI - Suicidal Ideation and Gestures”](#)**), psychosis, or aggressive behavior.
2. Explain that individuals with cognitive disorders may demonstrate disinhibited behavior, including disregard for social conventions and neglecting personal hygiene.
3. Explain that individuals with cognitive have poor judgment and insight, leading to underestimation of risks involved in activities, which may result in injuries or deaths.

COG-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in serving individuals with cognitive disorders.

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”](#).**

COG-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

COG-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of the cognitive disorder.

STANDARDS:

1. Discuss the nature of the cognitive disorder under consideration:
 - a. Post-concussional Disorder requires a history of a head trauma resulting in a cerebral concussion, difficulty in attention, memory, or learning, and at least 3 of the following:
 - i. Becoming fatigued easily
 - ii. Disordered sleep
 - iii. Headache
 - iv. Vertigo or dizziness
 - v. Irritability and aggressive behavior
 - vi. Anxiety, depression, and affective lability
 - vii. Changes in personality
 - viii. Apathy or lack of spontaneity
 - b. Mild Neurocognitive Disorder includes impairments in cognitive functioning lasting most of the time for a period of at least two weeks, and includes at least two of the following:
 - i. Memory impairment as indicated by reduced ability to learn or recall information.
 - ii. Disturbance in executive functioning (i.e., planning, organizing, abstracting, sequencing)
 - iii. Disturbance in attention or speed of information processing
 - iv. Impairment in perceptual-motor abilities
 - v. Impairment in language (e.g., comprehension, word finding)

2. Explain that this disorder causes significant impairment in functioning, and represents a significant decline from previous levels of functioning.
3. Explain that these disturbances do not meet the criteria for delirium, dementia, or another amnesic disorder, and are not better accounted for by another mental disorder, such as substance-related disorder or a psychotic disorder.

COG-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the care of the individual with a cognitive disorder.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

COG-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding cognitive disorders.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding cognitive disorders and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

COG-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of the individual with cognitive disorders.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

COG-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

COG-L LITERATURE

OUTCOME: The patient/family will receive literature about cognitive disorders.

STANDARDS:

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

COG-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.

COG-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

COG-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for addressing the conditions related to cognitive disorders.

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.

COG-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to cognitive disorders.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

COG-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to cognitive disorders.

STANDARDS:

1. Explain the potential dangers related to the patient's inability to care for self:
 - a. wandering out of the home
 - b. handling electrical or gas appliances, for example, leaving the food cooking on the stove
 - c. poor driving ability
 - d. other activities that require memory and good judgment
 - e. the current/potential abuse of alcohol or drugs
 - f. the need to secure medications and other potentially hazardous items
2. Discuss/review the safety plan with the family, including emergency procedures should the condition worsen, if suicidal or homicidal ideation arises, or if aggressive or dangerous behavior arises.
3. Discuss the safety precautions needed to prevent injuries. 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.
4. Review the local resources and phone numbers, including the police that may be utilized during a crisis, and may assist in transportation and safety compliance.
5. Discuss the potential for elder abuse/neglect (including financial exploitation) and ways to identify abuse/neglect. Refer as appropriate.

COG-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in coping with cognitive disorders.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in coping with cognitive disorders.
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.

COG-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test

2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

COG-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

COG-TX TREATMENT

OUTCOME: The family will understand the treatment plan.

STANDARDS:

1. Explain that some forms of cognitive disorders can be treated to partially or fully restore mental function, depending on the underlying medical condition, e.g., removing a brain tumor. Explain that when it cannot be restored, the treatment is to make life as easy as possible for the patient and caregivers.
2. Explain the treatment plan. Emphasize the importance of active participation by the family in the development of and participation in the treatment plan. 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.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.
 - a. Explain the physical activity, good nutrition, a calm, safe, and structured environment, and social interaction are important for keeping patients with cognitive disorder as functional as possible.

- b. Explain that an appropriate drug regimen can soothe agitation, anxiety, depression, and sleeplessness and may help boost participation in daily activities.
- c. 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).

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 common and important complications of this communicable disease.

STANDARDS:

1. Discuss the common complications of the communicable disease.
2. Describe the signs/symptoms of common complications of the communicable disease.

CDC-CM CASE MANAGEMENT

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

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"](#).**

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](#) (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 and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
 - g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

CDC-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

CDC-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of communicable diseases.

STANDARDS:

1. Explain the home management plan techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

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 the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.

CDC-L LITERATURE

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

STANDARDS:

1. Provide the 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

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 role of nutrition in this communicable disease.

STANDARDS:

1. Review adequate fluid intake.
2. Discuss nutritional modifications as related to the specific communicable disease.
3. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
4. Discuss the use of supplements to boost calorie intake, as appropriate.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

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](#)** (as appropriate)
2. Explain that certain infections can be dependent upon hygiene, social, and/or environmental conditions. **Refer to [“HPDP-HY Hygiene.](#)**
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 and fully participate in 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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management.](#)**
3. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

CDC-PRO PROCEDURES

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Discuss the indications, risks, and 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

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 test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results

- c. how results will impact or effect the treatment plan
- d. recommendations based on the test results

CDC-TX TREATMENT

OUTCOME: The patient/family will understand the treatment(s) proposed for the communicable disease.

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

CDC-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

COND - Conduct Disorder

COND-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications related to Conduct Disorder.

STANDARDS:

1. Explain that Conduct Disorder behaviors may lead to school suspension or expulsion, problems in work adjustment, problems at home, legal difficulties, sexually transmitted infections (**refer to [“STI - Sexually Transmitted Infections](#)**), unplanned pregnancy, and physical injury from accidents and fights.
2. Explain that suicidal ideation, attempts, and completions occur at a higher than expected rate.
3. Explain that those diagnosed with Conduct Disorder often have lower than average academic achievement and intelligence.
4. Explain that individuals diagnosed with Conduct Disorder are also at risk for developing Learning or Communication Disorders, Attention Deficit Hyperactivity Disorder (**refer to [“ADHD - Attention-Deficit/Hyperactivity Disorder](#)**), Posttraumatic Stress Disorder (**refer to [“PTSD - Posttraumatic Stress Disorder](#)**), other Anxiety and Mood Disorders, Personality Disorders (**refer to [“PERSD - Personality Disorder](#)**), and Substance-Related Disorders (**refer to [“AOD - Alcohol and Other Drugs](#)**).

COND-CM CASE MANAGEMENT

OUTCOME: The patient/family will understand the importance of integrated case management in treating Conduct Disorder.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family members, school personnel, 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](#)**.

COND-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

COND-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of Conduct Disorder.

STANDARDS:

1. Explain that Conduct Disorder is a persistent pattern of behavior in which the basic rights of others or age appropriate societal norms or rules are violated. It is present and usually diagnosed only in childhood or adolescence, as characterized by:
 - a. Aggression to people and animals, including bullying, threatening, initiating fights, and forcing sexual activity
 - b. Destruction of property, including setting fires
 - c. Deceitfulness or theft, including breaking into cars or homes, and breaking commitments
 - d. Serious violation of rules, including running away and truancy from school
2. Explain the associated features of Conduct Disorder, including little empathy or concern for others, poor frustration tolerance, low self-esteem, temper outbursts, recklessness, irresponsibility and blaming others for one's own misdeeds, and feigned remorse to reduce punishments.
3. Explain that Conduct Disorder is often associated with early onset of sexual behavior, drinking, smoking, use of illegal substances, and risk-taking acts.
4. Discuss the course of Conduct Disorder:
 - a. It may occur as early as 5 or 6 years old, and is rarely diagnosed after the age of 16 years old.
 - b. The course is variable, but early onset predicts a worse prognosis and increased risk of other disorders (**refer to [“COND-C Complications”](#)**).

- c. In a majority of individuals, the disorder remits in adulthood, although a substantial proportion continue to show behaviors that meet the criteria for Antisocial or Borderline Personality Disorder.
5. Explain that the disturbance causes clinically significant impairment in social, academic, or occupational functioning and must be present in two or more settings, e.g., school, home, and community.

COND-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in maintaining health in individuals diagnosed with Conduct Disorder.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

COND-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

COND-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g. smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

COND-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.

COND-L LITERATURE

OUTCOME: The patient/family will receive literature about Conduct Disorder

STANDARDS:

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

COND-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for Conduct Disorder.

STANDARDS:

1. Discuss lifestyle adaptations specific to Conduct Disorder, such as following rules, being respectful of self and others, avoiding risky behavior, and taking responsibility for one's own feelings and actions.
2. Discuss that the family may also require lifestyle adaptations to care for the patient, including creating greater structure in the home, being more involved with the child, taking responsibility for making the child's behavioral health appointments, and enforcing rules.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

COND-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. Medication may be prescribed to address aggressive behaviors or symptoms of co-occurring disorders.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

COND-PA PARENTING

OUTCOME: The patient/family will understand the parenting issues related to Conduct Disorder.

STANDARDS:

1. Discuss the appropriate methods for applying rewards and consequences to the patient with Conduct Disorder.
2. Emphasize the importance of consistency in applying rewards and consequences to change specific behaviors.

3. Discuss the need for appropriate physical and emotional involvement with child, which may include specific activities to improve the relationship.
4. Refer the parent(s) to parenting classes as appropriate.

COND-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of Conduct Disorder.

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. Emphasize that full participation and follow-up is critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain that the therapist and the patient will establish goals and duration of therapy together.

COND-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to Conduct Disorder, and the risk of suicide, aggressive behavior, or other risky behaviors.

STANDARDS:

1. Discuss/review the safety plan and/or administrative treatment plan with the patient and family, including the no-harm contract and emergency procedures.
2. Review the local resources and phone numbers, including the police that may be utilized during a crisis, and may assist in transportation and safety compliance.

COND-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect on the condition and precipitate depression or agitation.
2. Explain the role of effective stress management in preventing and/or abating mood changes and/or decompensation.

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.

COND-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

COND-TX TREATMENT

OUTCOME: The patient/family will understand the course of treatment and options for Conduct Disorder.

STANDARDS:

1. Explain that a combination of psychotherapy and medication interventions usually has better results than therapy or medication alone. The patient has a right to choose either option or both, and that the patient's active participation in the treatment decisions is critical to a good outcome.
2. Explain that therapists have different styles and orientations for treating Conduct Disorder, and that no one approach has been shown to be more effective than others, although some styles may suit the patient better.
 - a. Therapy may include anger management groups (in addition to individual psychotherapy) and the exploration and treatment of underlying traumatic events and co-occurring disorders.
 - b. Treatment is optimized when parents attend parenting classes, adjunct family therapy sessions, or their own individual psychotherapy sessions.
 - c. Administrative treatment plans are often useful to improve communication among providers, to prevent the patient's manipulations or splitting staff members, and to prevent suicidal or aggressive behaviors.
3. Explain that medications may be prescribed intermittently or throughout the treatment process.
 - a. Medication may be prescribed for address aggressive behaviors or symptoms of co-occurring disorders.
 - b. Explain that decisions about timing and duration of medication will be made jointly by the provider(s) and the patient.
4. Explain the importance for patients to learn to talk about any traumas in the safe context of the therapeutic environment.

CO - Constipation

CO-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of the colon in the intestinal tract.
2. Discuss changes to the intestinal tract as a result of constipation.

CO-C COMPLICATIONS

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

STANDARDS:

1. Explain that constipation is often a symptom of another condition. Constipation is defined as having fecal mass remain in the colon longer than 24-72 hours after meal ingestion or when patient strains to defecate.
2. Discuss common complications of constipation, which may include:
 - a. Increased narrowing of the colon with small, ribbon-like stools caused by inactivity, immobility, or obstruction.
 - b. Encopresis in infants and children resulting from poor bowel habits and poor fiber intake.
 - c. A delay in intestinal transit, gastric emptying, and decreased cholesterol and glucose absorption.
 - d. Medical assistance for diarrhea, bleeding, infection, and change in bowel habits.
 - e. Hemorrhoids.
3. Describe the common signs/symptoms of constipation which may include/experience:
 - a. Abdominal cramping/pain
 - b. Flatulence
 - c. Bloating
 - d. Changes in bowel habits
 - e. Soiling of clothing
 - f. Nausea and vomiting
 - g. Loss of appetite

CO-DP DISEASE PROCESS

OUTCOME: The patient/family will understand constipation.

STANDARDS:

1. Explain that constipation is often a symptom of another condition. Constipation is defined as having fecal mass remain in the colon longer than 24-72 hours after meal ingestion or when patient strains to defecate.
2. Describe the signs/symptoms of common complications of constipation which may include/experience:
 - a. Stools that are usually hard, dry, small in size, and difficult to eliminate.
 - b. Straining, bloating, and the sensation of a full bowel.
3. Explain that common causes of constipation, which may include but not limited to:
 - a. lack of fiber in the diet
 - b. lack of physical activity (especially in the elderly)
 - c. medications
 - d. irritable bowel syndrome
 - e. changes in life or routine such as pregnancy, aging, and travel
 - f. abuse of laxatives
 - g. ignoring the urge to have a bowel movement
 - h. dehydration
 - i. milk or milk products
 - j. specific diseases or conditions, such as stroke (most common)
 - k. problems with the colon and rectum
 - l. problems with intestinal function (chronic idiopathic constipation)
 - m. neurological disorders

CO-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in the prevention and treatment of constipation.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as weight loss, increased energy, improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.

3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.

CO-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

CO-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to prevent or correct constipation.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high-risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

CO-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to constipation.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.

CO-L LITERATURE

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

STANDARDS:

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

CO-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for the treatment and/or prevention of constipation.

STANDARDS:

1. Discuss lifestyle adaptations specific to constipation:
 - a. Changes that may help treat and/or prevent constipation include drinking enough water and other liquids, such as fruit and vegetable juices and clear soups.
 - b. Engaging in daily exercise.
 - c. Reserving enough time to have a bowel movement.

CO-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

CO-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for constipation.

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.

CO-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to constipation.

STANDARDS:

1. Emphasize that nutritional management includes adequate fluid intake, meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Emphasize the importance of adequate fiber intake, e.g., fresh fruits, fresh vegetables, and whole grains for the prevention of constipation.
4. Refer to registered dietitian for MNT or other local resources as appropriate.

CO-P PREVENTION

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

STANDARDS:

1. Discuss that constipation can often be prevented by dietary measures such as adequate water intake and a high fiber diet.
2. Discuss the importance of physical activity in the prevention of constipation.
3. Explain that laxatives and stool softeners may be indicated.

CO-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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections

5. Discuss pain management as appropriate.

CO-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - f. method of testing
 - g. necessity, benefits, and risks of test(s) to be performed
 - h. any potential risk of refusal of recommended test(s)
 - i. any advance preparation and instructions required for the test(s)
 - j. how the results will be used for future medical decision-making
 - k. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

CO-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 participation with treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.
5. Bowel retraining may be necessary.

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 guiding medical care and decision making to best serve the patient's care preferences.

STANDARDS:

1. Explain that many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is unable to provide guidance at the time that decisions need to be made.
3. Explain that Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences for care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.
6. Refer to ["ADV - Advance Directives"](#).

CAD-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

CAD-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to coronary artery disease.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with coronary artery disease as a life-altering illness that requires a change in lifestyle (refer to [“CAD-LA Lifestyle Adaptations”](#)).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with coronary artery disease, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. Refer to [“AOD - Alcohol and Other Drugs”](#).
6. Refer to a mental health agency or provider.

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”](#).

CAD-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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 of CAD.
3. Review the signs of coronary artery disease - substernal chest pain radiating to the jaw(s), neck, throat, arm(s), shoulder(s), or back. Nausea, weakness, shortness of breath, or diaphoresis (sweating) may accompany the pain.
4. Explain that chest pain is the discomfort felt when the heart muscle is deprived of oxygen.
5. Differentiate between angina (the temporary loss of oxygen to the heart muscle) and infarction (a permanent loss of oxygen to the heart muscle resulting in permanent damage and loss of function). Emphasize that angina is an important warning sign which should prompt immediate medical evaluation.
6. Explain that sometimes only a physician, through test interpretation, may be able to differentiate between angina and myocardial infarction.

CAD-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. Discuss and/or demonstrate proper use and care 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 and emphasize safe use of equipment.
4. Discuss proper disposal of associated medical 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. 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. Emphasize the importance of follow-up care.

2. Discuss the procedure and process for obtaining follow-up appointments.
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.

CAD-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding CAD.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding CAD and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

CAD-L LITERATURE

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

STANDARDS:

1. Provide the patient/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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

CAD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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](#).

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](#), [“HTN - Hypertension](#), [“LIP - Hyperlipidemia/Dyslipidemias](#), [“OBS - Obesity](#).

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 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.

3. 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.”](#)**
4. Explain that short-term use of narcotics may be helpful in pain management as appropriate.
5. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
6. 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. Discuss the indications, risks, and 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

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 test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test

2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

CAD-TO TOBACCO (SMOKING)

OUTCOME: The patient/family will understand the dangers of smoking.

STANDARDS:

1. Explain the increased risk of complications and chronic lung disease in the patient with coronary artery disease 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](#).

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.

CRIT - Critical Care

CRIT-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family 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 many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is able to provide guidance at the time that decisions need to be made.
3. Explain that the Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences of care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.

CRIT-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components that can accompany critical care.

STANDARDS:

1. Discuss the common difficulty in coping with being in a critical care unit and requiring critical care. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common to patients in critical care and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
2. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
3. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
4. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to ["AOD - Alcohol and Other Drugs"](#).**

5. Refer to a mental health agency or provider.

CRIT-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.

CRIT-C COMPLICATIONS

OUTCOME: The patient/family will understand the common complications associated with the patient's diagnosis and critical care treatment.

STANDARDS:

1. Discuss common complications associated the patient's diagnosis and treatment being used in the critical care unit.
2. Describe the signs/symptoms of common complications of the diagnosis and treatment and the importance of reporting them immediately.

CRIT-CM CASE MANAGEMENT

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

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”](#).**
4. Discuss the discharge plan for the patient, as appropriate.

CRIT-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

CRIT-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. **Refer to [“DIA - Dialysis”](#).**
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. A temporary catheter may be placed in a vein.
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 attention and evaluation.

CRIT-EQ EQUIPMENT

OUTCOME: The patient/family will understand the basic use of intensive care equipment.

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:

- a. indication for use
 - b. benefits of use
 - c. features and proper function of the equipment
 - d. signs of equipment malfunction and the anticipated staff responses, infection control principles, including hand hygiene and proper disposal of associated medical supplies
 - e. importance of not tampering with any medical device
2. Explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.

CRIT-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

CRIT-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to critical care.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.

3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

CRIT-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 that the patient must be intubated with an endotracheal tube or tracheostomy tube in order to receive mechanical ventilation.
2. Explain the basic procedure for endotracheal intubation, including the risks and benefits of endotracheal intubation and the adverse events which might result from refusal.
3. Discuss alternatives to endotracheal intubation, including expectant management, as appropriate.
4. Explain that the patient will be sedated and unable to speak or eat while intubated.
5. Discuss the potential necessity for using physical restraint to maintain intubation while the patient is heavily sedated and requiring mechanical ventilation.
6. Explain that the patient will be extubated as soon as it is medically feasible.

CRIT-IS INCENTIVE SPIROMETRY

OUTCOME: The patient/family 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 (head is elevated 30 to 45 degrees) which allows for free movement of the diaphragm.
3. Instruct the patient to exhale normally and evenly and 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.

CRIT-ISO ISOLATION

OUTCOME: The patient/family will understand the reasons and procedures for isolation of the patient in preventing and controlling the spread of Multidrug Resistant Organism (MDRO) infection.

STANDARDS:

1. Explain that isolation of the patient prevents the spread of the MDRO infection to healthcare providers, other patients, and family members.
2. Describe the type of isolation being implemented and associated precautions, protective equipment to be used:
 - a. Respiratory isolation
 - b. Contact precaution

CRIT-L LITERATURE

OUTCOME: The patient/family will receive literature regarding the critical care unit.

STANDARDS:

1. Provide patient/family with literature regarding the critical care unit.
2. Discuss the content of the literature.

CRIT-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for critical care.

STANDARDS:

1. Discuss lifestyle adaptations specific to critical care.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

CRIT-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

CRIT-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for critical 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.

CRIT-MON MONITORING

OUTCOME: The patient/family will understand the monitoring that will occur in critical care.

STANDARDS:

1. Explain the intense monitoring that is routinely provided for patients in critical care.

2. Discuss the various equipment that is used for monitoring, e.g. cardiac monitors, vital signs machines, blood glucose monitors, central venous and arterial catheters, oxygen saturation monitors.
3. Describe how the monitoring and frequency relates to the care being provided.

CRIT-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to critical care.

STANDARDS:

1. Emphasize the importance of nutrition to maintain and support energy needs, even while the patient cannot take nutrition orally.
2. As appropriate, explain that nutritional management for a patient requiring critical care may include feeding by nasogastric tube, by hyperalimentation via an IV catheter or central line, or feeding tubes.
3. Discuss the importance of regular meals and adequate fluid intake.
4. As appropriate, explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT.

CRIT-O2 OXYGEN THERAPY

OUTCOME: The patient/family will understand the need for oxygen administration.

STANDARDS:

1. Emphasize that O₂ flow rate should not be changed except upon the order of a physician, since altering the flow rate may worsen the condition.
2. Explain the reason for O₂ therapy and the anticipated benefit.

CRIT-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of developing the common complications of critical care.

STANDARDS:

1. Explain the intense monitoring and care that is provided to prevent complications and identify them if they occur.
2. Discuss potential treatments to reduce the chance of complications, including:
 - a. careful and regular hand hygiene for staff and visitors
 - b. assessing fall risk and implementing falls precautions, if indicated (**refer to ["FALL - Fall"](#)**)

- c. assessing pressure ulcer risk and implementing prevention measures if indicated (**refer to** ["PU - Pressure Ulcers"](#))
 - d. regular and frequent oral care with an antiseptic agent
 - e. isolation precautions, as appropriate
3. **Refer to** ["VENT-VAP Ventilator-Associated Pneumonia"](#), ["UCATH-P Prevention"](#).

CRIT-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that the patient's pain and level of anxiety will be monitored closely while requiring critical care.
2. 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.
3. Explain that pain management is specific to the disease process and the patient, and it may be multifaceted. **Refer to** ["PM - Pain Management"](#).
4. Explain that adequate medication will be administered to maintain the patient's comfort, including the anxiety that frequently accompanies critical care. This may include IV or epidural medication infusions or boluses.
5. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
6. Explain non-pharmacologic measures that may be helpful with pain control.

CRIT-PRO PROCEDURE

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, as well as the alternative and the risk of non-treatment. Procedures may include anesthesia, intubation, blood transfusion, central venous catheters, arterial lines, cardiac pacing, dialysis, endoscopy, urinary catheter insertion, nasogastric tube insertion, chest tube insertion, ventilatory support with CPAP/BiPAP or mechanic ventilation. **Refer to** ["ANS - Anesthesia"](#), ["BL - Blood Transfusions"](#), ["CVC - Central Line Catheter"](#), ["DIA - Dialysis"](#), ["SPE - Surgical Procedures and Endoscopy"](#), ["UCATH - Urinary Catheter and Associated Infection"](#), ["VENT - Ventilation \(Mechanical\) and Associated Pneumonia"](#).
2. Explain the process and what is expected after the procedure.

3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

CRIT-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”](#).**
2. Reassure the patient/family that the staff is trained and competent to handle these issues.
3. Discuss, as appropriate, the potential necessity for using physical restraint while the patient is heavily sedated and requiring critical care. **Refer to [“RST - Restraints and Seclusion”](#).**
4. Emphasize the importance of openness and honesty with the therapist.
5. Explain the intense monitoring and care that is provided for safety, to prevent complications and identify them if they occur.
6. Emphasize the importance of requesting assistance when attempting to get out of bed or ambulating. Discuss assessing fall risk and implementing falls precautions if indicated. **Refer to [“FALL - Fall”](#).**

CRIT-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to critical care.

STANDARDS:

1. Explain that there are numerous alarms associated with critical care that notify staff when there is an issue with the equipment or the patient. Explain that some of these are routine notification alarms and some require immediate action.

2. Reassure the patient/family that the staff is trained and competent to handle these issues.
3. Discuss, as appropriate, the potential necessity for using physical restraint while the patient is heavily sedated and requiring critical care. Refer to [“RST - Restraints and Seclusion”](#).
4. Explain the intense monitoring and care that is provided for safety, to prevent complications and identify them if they occur.
5. Emphasize the importance of requesting assistance when attempting to get out of bed or ambulating. Discuss assessing fall risk and implementing falls precautions if indicated. Refer to [“FALL - Fall”](#).

CRIT-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
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.

CRIT-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

CRIT-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

CRIT-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.

3. Explain the correct procedure for caring for this patient's wound, including the use of equipment such as a wound vac and personal protective equipment.

CRN - Crohn's Disease

CRN-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to Crohn's Disease.

STANDARDS:

1. Explain the normal anatomy and physiology of the GI track (mouth to colon) or the affected site such as the distal ileum and colon.
2. Discuss the changes to anatomy and physiology as a result of inflammation in the mucosal layers of the GI track.
3. Discuss the impact of these changes on the patient's health or well-being.

CRN-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to Crohn's Disease.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with Crohn's Disease as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with Crohn's Disease, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the management incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to ["AOD - Alcohol and Other Drugs"](#).**
6. Refer to a mental health agency or provider.

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, weight loss, and/or disability.

CRN-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in Crohn's disease.

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 care 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"](#).**

CRN-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

CRN-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology and symptoms of Crohn's disease.

STANDARDS:

1. Explain that Crohn's disease is a chronic inflammatory disease of the digestive system. The etiology is unknown.
2. Explain that Crohn's disease may be hereditary and it presents 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 cramping after meals.
4. Explain that chronic watery diarrhea results from edema, bile salt malabsorption, bacterial overgrowth, and ulceration, and may be accompanied by bloody stools.
5. Explain that in some patients, the inflamed intestine may perforate and form intra-abdominal and anal abscesses.
6. Explain that this condition is characterized by exacerbations and remissions that may be abrupt or insidious.

CRN-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

CRN-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.

2. Discuss the procedure and process for obtaining follow-up appointments.
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding Crohn's disease.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding Crohn's disease and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

CRN-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of Crohn's disease.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, 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-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for Crohn's disease.

STANDARDS:

1. Discuss lifestyle adaptations specific to Crohn's disease.

2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

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 nutrition, as it relates to Crohn's disease.

STANDARDS:

1. Emphasize that nutrition intervention such as meal planning, careful shopping, appropriate food preparation and regular meals may prevent or slow progression of disease.
2. Discuss the role of supplements, fats, fiber and adequate fluid intake.
3. Explain the importance of calcium and vitamin D and alternate sources of milk.
4. Discuss that seasoning are poorly tolerated and should be avoided.
5. Explain to that parenteral hyperalimentation may be necessary to maintain nutrition while allowing the bowel to rest
6. Refer to registered dietitian for MNT or other local resources as appropriate.

CRN-P PREVENTION

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

STANDARDS:

1. Discuss the need to adhere to nutrition intervention.
2. Explain the importance of following the treatment plan.

CRN-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing:
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs

- e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications
 3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
 4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
 5. Refer for medical and psychosocial support services for any risk factor identified.

CRN-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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

CRN-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

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"](#).**
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. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

CRN-TX TREATMENT

OUTCOME: The patient/family will understand the appropriate treatment for bowel disease.

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation in the treatment plan.

2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

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"](#).**

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.”](#)

CRP-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

CRP-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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 the child 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, because 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

CRP-SHS SECOND-HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Explain that second-hand smoke is known as "passive smoking." Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, and many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness when exposed to cigarette smoke either directly or via second-hand/third-hand smoke.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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-OT Quit."](#)**

CRP-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

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-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to cystic fibrosis.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with cystic fibrosis as a life-altering illness that requires a change in lifestyle (**refer to [“CF-LA Lifestyle Adaptations](#)”).**
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with cystic fibrosis, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).”**
6. Refer to a mental health agency or provider.

CF-C COMPLICATIONS

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

STANDARDS:

1. Discuss pulmonary/respiratory complications of cystic fibrosis as appropriate.
2. Discuss possible effects of CF on the pancreas:

- a. Exocrine pancreatic failure may cause fat malabsorption and lead to growth delay or failure.
- b. Endocrine pancreatic failure may lead to glucose intolerance or insufficient insulin secretion.
3. Discuss that cirrhosis may result from severe forms of cystic fibrosis.
4. 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.”](#)**

CF-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

CF-DP DISEASE PROCESS

OUTCOME: The patient/family will understand 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:
 - a. Is a chronic and progressive disease that causes mucus to become thick, dry, and sticky.
 - b. Results in end organ problems especially in the lungs, pancreas, and spermatid tubules.
 - c. Is not caused by environment, diet, exercise, or other lifestyle behaviors.
 - d. Is not contagious and cannot be passed from one person to another except through inheritance.
 - e. Is usually diagnosed during childhood.
3. Explain that course of cystic fibrosis varies.
4. 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 and demonstrate (when appropriate) the proper use and care of the equipment.

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.
4. Emphasize the safe use of equipment, e.g., no smoking around O₂, use of gloves, electrical cord safety, and disposal of sharps.

CF-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. 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 the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

CF-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding cystic fibrosis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding cystic fibrosis and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

CF-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of cystic fibrosis.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

CF-L LITERATURE

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

STANDARDS:

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

CF-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for cystic fibrosis.

STANDARDS:

1. Discuss lifestyle adaptations specific to cystic fibrosis.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.

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.

CF-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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. Refer to a registered dietitian for MNT, if available.

CF-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

CF-SHS SECOND HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Explain that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, and many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness when exposed to cigarette smoke either directly or via second-hand/third-hand smoke.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-hand smoke.
5. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness. Encourage smoking cessation or at least never smoking in the home or car. Refer to [“TO - Tobacco Use.”](#)

CF-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in cystic fibrosis.
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.

CF-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

CF-TO TOBACCO (SMOKING)

OUTCOME: The patient/family will understand the dangers of smoking in the patient with cystic fibrosis.

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 - Tobacco Use](#).

CF-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 participation in the treatment plan.

2. Explain that management of cystic fibrosis varies from person to person depending on the organ systems which are involved. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

D**DVT - Deep Vein Thrombosis****DVT-AP ANATOMY AND PHYSIOLOGY**

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

STANDARDS:

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

DVT-C COMPLICATIONS

OUTCOME: The 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: The 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.

DVT-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

DVT-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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 the 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
 - c. Discuss any significant drug/drug or drug/food interactions, including interaction with alcohol.
3. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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/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 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-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare

5. Refer for medical and psychosocial support services for any risk factor identified.

DVT-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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.
3. Discuss the importance of fully participating in the treatment plan, including scheduled follow-up.

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.
4. Discuss that dehydration may result from a wide range of diseases and states that impair water homeostasis in the body, including external or stress-related causes, infectious diseases, malnutrition, food borne illness, and diabetes.
 - a. Discuss external or stress related causes: excessive sweating, blood loss or hypotension due to physical trauma, diarrhea, hyperthermia, shock (hypovolemic), vomiting, burns, use of methamphetamine, amphetamine, caffeine and other stimulants and excessive consumption of alcoholic beverages.
 - b. Discuss infectious diseases related to dehydration: Cholera, gastroenteritis, and shigellosis.
 - c. Discuss malnutrition as it relates to dehydration including fasting, electrolyte disturbances, and rapid weight loss

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 sweating, draining wounds, ketoacidosis, hemorrhage, prolonged heat exposure. **Refer to [“DEH-AP Anatomy and Physiology”](#).**
3. Discuss possible signs/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).

DEH-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the importance of water or electrolyte fluid intake during exercise, especially in warm climates, to prevent dehydration.
3. Discuss discontinuing exercise during periods of dehydration and resuming when dehydration is resolved.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

DEH-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.

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.

DEH-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

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/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 in 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.
4. Discuss the importance of being aware of local weather conditions, such as the heat index and humidity levels. Athletes, coaches, and outdoor enthusiasts need to be diligent about maintaining hydration. Remind the elderly and small children to re-hydrate frequently during extreme heat conditions.
5. Discuss that water is the best source of hydration. Sport drinks should only be used after 60 to 90 minutes of intense activity.
6. Explain that thirst is unreliable to determine fluid needs, therefore drink fluids before and after engaging in physical activities.

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.
 - a. Usually, fluid replacement will include electrolytes.
 - b. Commercial rehydration solutions may be advised (Pedialyte, Infalyte, or other balanced electrolyte solutions).
 - c. In severe cases of nausea and vomiting, popsicles or ice chips are better tolerated. **Refer to [“GE-TX Treatment”](#).**
2. Discourage the use of caffeinated beverages because they are mild diuretics and may lead to increased loss of water and sodium.
3. Discourage the use of alcoholic beverages (including beer and wine coolers) because they actively dehydrate via enzymatic activity.
4. Explain that the fluid replacement via the intravenous route may be necessary if dehydration is severe or oral fluids are not tolerated.

DEL - Delirium

DEL-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components as it relates to delirium.

STANDARDS:

1. Discuss the potential stress and other emotional reactions that are common in with delirium, and the danger of further complications or mental health diagnoses related to it.
2. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
3. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
4. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs to cope with the stress of diagnosis. **Refer to [“DEL - Delirium”](#).**
5. Refer to a mental health agency or provider.

DEL-C COMPLICATIONS

OUTCOME: The family will understand the potential complications of delirium.

STANDARDS:

1. Explain that people with other serious, chronic, or terminal illnesses may not regain their pre-delirium levels of thinking skills or functional abilities, and may also have a general decline in health, poor recovery from surgery, a need for institutional care, and an increased risk of death.
2. Explain that individuals with delirium often exhibit emotional disturbances such as anxiety, fear, depression, irritability, anger, euphoria, and apathy, which are often in response to hallucinations, illusions, or transient delusions.
3. Explain the need for constant supervision and the potential dangers related to delirium that may lead to injuries, such as attempting to get out of bed when it is unsafe or untimely, or trying to escape while attached to IV lines, respiratory tubes, urinary catheters, or other medical equipment.

DEL-CM CASE MANAGEMENT

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

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”](#).**

DEL-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

DEL-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms, etiology, and course of delirium.

STANDARDS:

1. Discuss the essential features of delirium, involving:
 - a. a disturbance in consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain, or shift attention
 - b. a change in cognition (such as memory deficit, disorientation to time or place, or language disturbance) or development of a perceptual disturbance, such as hallucinations, illusions, or delusions
2. Discuss the etiology of the delirium:
 - a. medical condition (e.g., infection, endocrine abnormalities)
 - b. substance intoxication or withdrawal
 - c. use of medication
 - d. toxin exposure

- e. a combination of these factors
3. Explain that the course of delirium develops over a short period of time (usually hours to days), tends to fluctuate during the course of the day, and usually resolves within hours to as long as several weeks or months.
4. Discuss the differential diagnosis, and rule out the presence of a pre-existing or evolving dementia.

DEL-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in coping with delirium.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

DEL-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

DEL-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to delirium, and the patient's decline in ability to tend to own hygiene.

STANDARDS:

1. Discuss the importance of hygiene in infection control.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

DEL-L LITERATURE

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

STANDARDS:

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

DEL-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

DEL-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for addressing the conditions related to delirium.

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.

DEL-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to delirium and associated conditions.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

DEL-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of developing delirium or preventing a worsening of the condition

STANDARDS:

1. Discuss the risk factors that may trigger a delirium, and ways to avoid them. Some triggers may include loud noises, unfamiliar surroundings, lack of stimulating activities, use of psychoactive drugs, interrupted sleep, lack of adequate food and fluids (refer to [“DEL-N Nutrition”](#)), and pain.
2. Discuss the importance of prompt and appropriate treatment of general medical conditions, proper nutrition and fluid and electrolyte balance, sensory aids, and proper sensory stimulation.
3. Explain the importance of regular, simple communication about time and place to help the patient with orientation.

DEL-S SAFETY

OUTCOME: The family will understand safety as it relates to delirium.

STANDARDS:

1. Explain the potential dangers related to the patient’s disorientation and inability to care for self, including falling out of bed, trying to leave while attached to medical equipment, and involvement in activities that require memory and attention.
2. Discuss/review the safety plan and precautions to prevent injury, including emergency procedures should the condition worsen or dangerous behaviors arise.
3. Review the local resources and phone numbers, including the police that may be utilized during a crisis, and may assist in transportation and safety compliance.

DEL-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in coping with a family member diagnosed with delirium.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in coping with this diagnosis.
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.

DEL-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

DEL-TX TREATMENT

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

STANDARDS:

1. Explain that the primary goal of treatment is to address the underlying causes or triggering factors, such as stopping the use of a particular medication or treating an infection, as well as co-morbid conditions.
2. Explain the treatment plan and emphasize the importance of creating optimal environment for healing the body and calming the mind.

3. Explain that the use of anti-psychotic medication is sometimes prescribed to calm a patient who is confused and agitated, or when the symptoms interfere with necessary medical treatment, threatens the safety to self and others, and non-pharmacological approaches have failed.
4. Explain that supportive care aims to prevent complications by protecting the airway, providing fluids and nutrition, assisting with movement, treating pain, and keeping the patient oriented to his or her surroundings. **Refer to [“DEL-P Prevention”](#)**.
5. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.

DEM - Dementia

DEM-ADL **ACTIVITIES OF DAILY LIVING**

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

STANDARDS:

1. Discuss the importance of supervising the patient's 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), or learning to assume responsibility of ADLs on behalf of the patient.
2. Assist the 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.

DEM-ADV **ADVANCE DIRECTIVE**

OUTCOME: The patient/family 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 many persons are not able to make their own decisions when ill. The advance directive and its role maintains a sense of control in the patient's medical care and decisions.
2. Explain that this statement of preferences is only used to guide decision making if the patient is able to provide guidance at the time that decisions need to be made.
3. Explain that the Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences of care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.

DEM-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to dementia.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of their loved one being diagnosed with dementia as a life-altering illness that requires a change in lifestyle for the entire family (**refer to [“DEM-LA Lifestyle Adaptations”](#)**).
2. Discuss the potential stress and other emotional reactions that are common in coping with dementia, and the danger of further complications or mental health diagnoses related to it.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#)**.
6. Refer to a mental health agency or provider.

DEM-C COMPLICATIONS

OUTCOME: The family will understand the potential complications of dementia.

STANDARDS:

1. Explain that individuals with dementia may often develop comorbid conditions, such as depression (**refer to [“DEP - Depressive Disorders”](#)**), delirium (**refer to [“DEL - Delirium”](#)**), suicidal behavior (**refer to [“SI - Suicidal Ideation and Gestures”](#)**), psychosis, or aggressive behavior.
2. Explain that individuals with dementia typically demonstrate disinhibited behavior, including disregard for social conventions, such as inappropriate jokes, undue familiarity with strangers, and neglecting personal hygiene.
3. Explain that individuals with dementia have poor judgment and insight, leading to underestimation of risks involved in activities, which may result in injuries or deaths.
4. Explain that individuals with dementia are at risk for malnutrition, falls, and physical debility.

DEM-CM CASE MANAGEMENT

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

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”](#).**

DEM-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

DEM-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of dementia.

STANDARDS:

1. Discuss the essential features of dementia involving the development of multiple cognitive deficits that include both:
 - a. Memory impairment (impaired ability to learn new information or to recall previously learned information)
 - b. One or more of the following cognitive disturbances:
 - i. Aphasia (language disturbance)
 - ii. Apraxia (impaired ability to carry out motor activities despite intact motor function)
 - iii. Agnosia (failure to recognize or identify objects or faces despite intact sensory function)
 - iv. Disturbance in executive functioning (i.e., planning, organization, sequencing, abstracting, reasoning)
2. Explain the etiology of the dementia and the specific type of dementia:

- a. **Dementia of the Alzheimer's Type** is diagnosed when the other causes have been ruled out, including other central nervous conditions (e.g., cerebrovascular disease, subdural hematoma, brain tumor, or other listed condition), systemic conditions known to cause dementia (e.g., hypothyroidism, niacin, or folic acid deficiency, HIV), and substance-induced conditions. **Refer to [“ALZ - Alzheimer’s Disease”](#)**.
 - b. **Vascular Dementia** is diagnosed when the above cognitive and memory impairments are accompanied by focal neurological signs and symptoms (e.g., exaggeration of deep tendon reflexes, gait abnormalities), or laboratory evidence of cerebrovascular disease (e.g., multiple infarctions involving the cortex and underlying white matter). **Refer to [“CVA - Cerebrovascular Disease”](#) and [“PVD - Peripheral Vascular Disease”](#)**.
 - c. **Substance-Induced Persisting Dementia** which includes alcohol, drugs of abuse.
 - d. **Dementia Due to General Medical Conditions** is judged to be the direct pathophysiological consequences of specific conditions, including:
 - i. HIV
 - ii. Head Trauma, which does not involve a gradual onset
 - iii. Parkinson's Disease
 - iv. Huntington's Disease
 - v. Other conditions, such as brain tumors, structural lesions, and endocrine conditions
3. Explain that the course of dementia often has a gradual onset (depending on the cause), involves a continuing cognitive decline from previous norms, and interferes with occupational or social functioning. Explain that acute medical illness can cause more rapid, irreversible decline.
 4. Discuss the differential diagnosis, and rule out that deficits are not only present during a delirium.

DEM-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in coping with dementia.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.

4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Encourage walking or light exercise to stimulate appetite.
6. Refer to community resources as appropriate.

DEM-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

DEM-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding dementia.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding dementia and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

DEM-HM HOME MANAGEMENT

OUTCOME: The patient/family/caregiver will understand home management of dementia 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 in 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.
 - h. Encourage the patient to exercise the mind by reading, puzzles, writing, etc. as appropriate. Avoid challenging to the point of frustration.
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. Explain the importance of supervising the patient during bathing and eating. Discourage leaving the patient alone for extended periods. **Refer to [“DEM-S Safety”](#).**
 5. Explain that over the course of the disease, home management will require frequent adjustments.
 6. Encourage assistance with activities of daily living as appropriate. 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.

DEM-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary

4. Review the community resources available for help in achieving behavior changes.

DEM-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to dementia, and the patient's decline in ability to tend to own hygiene.

STANDARDS:

1. Discuss the importance of washing in infection prevention.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

DEM-L LITERATURE

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

STANDARDS:

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

DEM-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 that the caregiver 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.

DEM-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

DEM-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for addressing the conditions related to dementia.

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.

DEM-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to dementia and associated conditions.

STANDARDS:

1. Review normal nutritional needs for optimum health.
2. Explain the importance of serving small, frequent meals and snacks by offering a variety of food textures, colors, and temperatures. Explain the importance of serving high calorie foods first. Offer favorite foods. Discourage force feeding the patient.
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. Encourage walking or light exercise to stimulate appetite.
6. 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 dietitian for MNT as appropriate.

DEM-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.

DEM-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to dementia.

STANDARDS:

1. Explain the potential dangers related to the patient's inability to care for self
 - a. wandering out of the home at night

- b. handling electrical or gas appliances, for example, leaving the food cooking on the stove
 - c. poor driving ability
 - d. other activities that require memory and good judgment
 - e. the current/potential abuse of alcohol or drugs.
 - f. the need to secure medications and other potentially hazardous items
2. Discuss/review the safety plan with the family, including emergency procedures should the condition worsen, if suicidal or homicidal ideation arises, or of aggressive or dangerous behavior arises.
 3. Discuss the safety precautions needed to prevent injuries. 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.
 4. Review the local resources and phone numbers, including the police that may be utilized during a crisis, and may assist in transportation and safety compliance.
 5. Discuss the potential for elder abuse/neglect (including financial exploitation) and ways to identify abuse/neglect. Refer as appropriate.

DEM-SM STRESS MANAGEMENT

OUTCOME: The family will understand the role of stress management in coping with a family member diagnosed with dementia.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in coping with the changes in lifestyle.
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.

DEM-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

DEM-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

DEM-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 some forms of dementia can be treated to partially or fully restore mental function, depending on the underlying medical condition, e.g., removing a brain tumor. Explain that when it cannot be restored, the treatment is to make life as easy as possible for the patient and caregivers.
2. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation in the treatment plan. 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.
3. Discuss treatments that may be utilized, depending on the cause of the illness, and any co-morbid conditions.:
 - a. Explain that physical activity, good nutrition, a calm, safe, and structured environment, and social interaction are important for keeping patients with dementia as functional as possible.
 - b. Explain that an appropriate drug regimen can sooth agitation, anxiety, depression, and sleeplessness and may help boost participation in daily activities.
 - c. 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).
4. Refer to ["EOL - End of Life"](#).

DC - Dental Caries

(Correlates to American Dental Association (ADA) codes 1310 and 1330)

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 cementum - 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 nerve.
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. **Refer to [“ECC - Early Childhood Caries”](#).**
5. Discuss the need for prophylactic antibiotics before dental work as indicated to prevent cardiac complications or complications with joint replacements.

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"](#).**
 - c. Children whose parents have active tooth decay.
 - d. Lack of fluoride.
 - e. Gingival recession.
 - f. Persons having undergone radiation therapy.
 - g. Genetic predisposition.
 - h. Excessive vomiting and reflux.
 - i. Certain medications.
 - j. History of caries.

DC-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

DC-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

DC-HY HYGIENE

OUTCOME: The patient/family will recognize good oral hygiene as an aspect of wellness.

STANDARDS:

1. Review the importance of daily dental hygiene, with attention to brushing and flossing.
2. Discuss the sharing of items, such as food, pacifiers, may contribute to dental caries.

DC-L LITERATURE

OUTCOME: The patient/family will receive literature about dental care.

STANDARDS:

1. Provide the 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

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. **Refer to ["ECC - Early Childhood Caries"](#).**
3. Discuss the importance of calcium and fluoride intake as it relates to tooth development and mineralization.
4. Refer to a registered dietitian 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. Discuss factors that decrease the risk of caries:

- a. 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.
 - b. Fluoride strengthens teeth and may rebuild the early damage caused by bacteria/acid attacks.
 - i. 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/provider to determine if the drinking water contains adequate fluoride and if supplementation is needed.
 - ii. Explain that the use of fluoride may be used to prevent decay.
 - iii. Sealants may prevent dental caries.
3. Discuss factors that increase the risk of caries:
- a. Frequency of carbohydrate consumption increases the rate of acid attacks, thereby increasing the risk of dental decay. **Refer to [“DC-N Nutrition”](#).**
 - b. 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 recession of gingival tissue (gums) exposes the softer cementum 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 [“PERIO - Periodontal Disease”](#).**
 - 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 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 and patient and may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.

4. Explain non-pharmacologic measures that may be helpful with pain control.
5. Explain that the best management of dental pain is definitive care (restoration, root canal or extraction).

DC-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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

DC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test

2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on 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 tobacco cessation. If the patient is not ready to quit, emphasize the importance of cutting back on the amount of tobacco in an effort to quit. **Refer to [“TO - Tobacco Use”](#).**

DC-TX TREATMENT

OUTCOME: The patient/family will understand the necessary 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”](#).**
4. Discuss the indications for immediate follow-up, e.g., continued bleeding, fever, persistent or increasing pain.

DC-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.

2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

DEP - Depressive Disorders

DEP-C COMPLICATIONS

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

STANDARDS:

1. Explain that the presence of depressive disorders may complicate the course of a general medical condition or illness, e.g. decreased compliance with medical recommendations or increased length of hospital stays, and warrant additional, clinical attention.
2. Explain that depressive disorders may worsen and develop co-morbid conditions, including psychotic features, anxiety disorders, alcohol or drug addiction (**refer to [“AOD - Alcohol and Other Drugs](#)**), personality disorders (**refer to [“PERSD - Personality Disorder](#)**), heart disease (**refer to [“CAD - Coronary Artery Disease](#)**), and other medical conditions.
3. Explain that untreated depression may interfere with school or work performance, and may lead to social isolation, family conflicts, and other relationship difficulties.
4. Explain that depressive disorders are associated with increased risk of self-injurious behavior and suicide (**refer to [“SI - Suicidal Ideation and Gestures](#)**), especially if left untreated.

DEP-CM CASE MANAGEMENT

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

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](#).**

DEP-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

DEP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the specific depressive disorder.

STANDARDS:

1. Discuss the common symptoms of depressive disorder, which may include:
 - a. persistent sadness, depressed mode, or irritability
 - b. Anhedonia, which is loss of interest and pleasure in all or almost all activities
 - c. changes in appetite or significant weight loss or gain
 - d. insomnia or hypersomnia
 - e. psychomotor agitation or retardation
 - f. fatigue or loss of energy
 - g. feeling of worthlessness or excessive or inappropriate guilt
 - h. diminished ability to think or concentrate, or indecisiveness
 - i. recurrent suicidal thoughts. Refer to [“SI - Suicidal Ideation and Gestures](#).
2. Explain that depressive disorders often include other associated symptoms, such as memory loss, feelings of hopelessness, low self esteem, and decreased libido/sexual drive.
3. Explain the presentation and course of the specific depressive disorder:
 - a. **Major Depressive Disorder** includes the presence of at least one major depressive episode in one’s life, as indicated five or more of the depressive symptoms, experienced most of the day, nearly every day for at least two consecutive weeks, and represents a change from previous functioning.
 - b. **Dysthymic Disorder** includes two or more symptoms of depression, usually less intense, but lasting continuously for at least two years (or 1 year for children). No Major Depressive episode has been present during the first two years of the disorder.
 - c. **Depressive Disorder Not Otherwise Specified (NOS)** includes disorders with depressive features that do not meet criteria for other depressive disorders or adjustment disorders, including minor depressive disorder, recurrent, brief

depressive disorder, premenstrual dysphoric disorder, or unclear depressive presentations.

4. Explain that depressive disorders may only diagnosed if no manic episode, mixed episodes, hypomanic episodes have been experienced in the patient's life, and did not occur exclusively during a psychotic disorder, a general medical condition, or as a result of the use of a substance.
5. Discuss the effect that depression may have on the patient's ability to function at work, school, and leisure activities.
6. Explain that depression has a variety of courses, onset, and presentation, and while the cause is unknown, but it is considered to include combination of influences: biological differences, brain chemistry/neurotransmitters, hormonal factors, inherited traits, life events, and childhood trauma.

DEP-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in the treatment or management of depression.

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.

DEP-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care, and the need for continuous mental health services until the provider and patient jointly agree to terminate the treatment.
2. Emphasize the importance of immediate follow-up and crisis intervention if suicidal thoughts arise.
3. Discuss the procedure and process for obtaining follow-up appointments.

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

DEP-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help/crisis intervention line.

STANDARDS:

1. Explain a help/crisis intervention line may assist in dealing with an immediate crisis, including suicidal ideation.
2. Provide the help/crisis intervention line phone number and hours of operation, such as a local crisis hotline or the national hotline 1-800-.273-TALK or www.suicidepreventionlifeline.org.
3. Explain how the help/crisis line works and what can be expected from calling and/or participating in the services.

DEP-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high-risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

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 depressive disorders.

STANDARDS:

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

DEP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for coping with depression.

STANDARDS:

1. Discuss lifestyle adaptations changes that may be used as tools for coping with depression, in conjunction with professional intervention, including:
 - a. Learn and keep track of the warning signs of depression to explore potential triggers of depressive episodes.
 - b. Go to therapy appointments, even when feeling well.
 - c. Get regular exercise (**refer to [“DEP-EX Exercise](#)**).
 - d. Eat small, well balanced meals (**refer to [“DEP-N Nutrition](#)**).
 - e. Get adequate sleep.
 - f. Reduce isolation by strong social supports.
 - g. Avoid alcohol or illicit drugs.
 - a. Reduce stress (**refer to [“DEP-SM Stress Management](#)**).
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

DEP-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. Some medication may take up to six 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

DEP-MNT MEDICAL NUTRITION THERAPY

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

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-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to depression.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Explain that caffeine and other herbal supplements should be avoided with medication use.
4. Discuss the use of food as a coping mechanism and its role in eating disorders.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

DEP-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce the effects of depression or prevent recurrence of depressive episodes.

STANDARDS:

1. Explain and discuss ways of developing and enhancing specific internal coping strategies, resiliency, and stress management techniques (**refer to [“DEP-SM Stress Management”](#)**), which may include seeking out humor or laughter, living a healthy lifestyle (i.e., appropriate exercise, diet, meditation), and thinking positively about oneself.
2. Discuss methods to prevent future depressive episodes, including taking medications as prescribed and continuing psychotherapy, even after symptoms have improved.
3. Discuss the importance of developing and enhancing appropriate external support systems and resources.
4. Discuss ways of avoiding stressful situations that may lead to significant distress.

DEP-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of depression.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.

6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

DEP-S SAFETY

OUTCOME: The patient/family will understand the safety plan as it relates to severe depression, and potential suicidal ideation and/or behavior.

STANDARDS:

1. Discuss/review the safety plan with the patient and family, including the no-harm contract and emergency procedures if the condition worsens, if suicidal or homicidal ideation arises, or if the patient feels urges to engage in risky/dangerous behavior.
2. Discuss the potential and process of voluntary or involuntary hospitalization should the patient have difficulties staying safe or refraining from acting on the impulses to hurt oneself.
3. Explain that local police may also be available to assist in transportation and safety compliance.
4. Explain the importance of reporting any abuse, neglect, or potentially dangerous situations.

DEP-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress is linked with the onset of depressive disorder and contributes to more severe symptoms of depression.
2. Explain that uncontrolled stress can interfere with the treatment of depressive disorder.
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, 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.

DEP-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

DEP-TX TREATMENT

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

STANDARDS:

1. Explain that a combination of psychotherapy and medication interventions usually have better results than therapy or medication alone. The patient has a right to choose either option or both. Discuss the treatment options:
 - a. Explain that psychotherapists have different styles and orientations for treating depression, and some styles may suit the patient better.

- b. Explain that medications are very effective in managing depressive symptoms, and may be prescribed on an individualized basis, depending on the severity of the illness. **Refer to [“DEP-M Medications”](#).**
 - c. Explain that psychiatric hospitalization is sometimes necessary when depression worsens, and suicidal thoughts arise.
2. Explain the lifestyle changes that are an important part of treatment (**refer to [“DEP-LA Lifestyle Adaptations”](#)**).
3. Explain to the patient/family that the prognosis is often good with appropriate treatment.
4. Explain that the treatment plan will be made by the patient and treatment team after reviewing available options. Explain that treatment for depression may vary according to the patient’s life circumstances, severity of the condition, and available resources.

DM - Diabetes Mellitus

DM-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Discuss normal glucose metabolism and pancreatic function.
2. Briefly describe the pathophysiology of this patient's diabetes:
 - a. Type 2
 - i. Explain that type 2 diabetes involves insulin resistance in skeletal muscle, inappropriate glucose dumping by the liver, and/or a relative insulin deficiency.
 - ii. Many of these physiologic changes may begin 5-7 years prior to diagnosis and that end-organ damage may be occurring during that time.
 - iii. Explain that excessive insulin secretion by the pancreas may lead to beta cell damage and eventual insulin deficiency.
 - b. Type 1
 - i. Discuss that complete pancreatic beta cell destruction results in loss of insulin production and the need for life long insulin.
 - ii. Type 1 diabetes is characterized by rapid onset and ketoacidosis.
3. Discuss the impact of these changes on the patient's health or well-being.

DM-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to diabetes.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with diabetes as a life-altering illness that requires a change in lifestyle (**refer to [“DM-LA Lifestyle Adaptations”](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with diabetes, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.

5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).**
6. Refer to a mental health agency or provider.

DM-C COMPLICATIONS

OUTCOME: The patient/family will understand the importance of controlling blood sugar, blood pressure, and lipids to reduce the risk of complications from diabetes.

STANDARDS:

1. Discuss common complications of long term hyperglycemia and/or hypertension and/or dyslipidemia, for example:
 - a. Retinopathy (**refer to [“ODM - Ocular Diabetes Mellitus](#)**)
 - b. Sensorimotor and autonomic neuropathy
 - c. Nephropathy (**refer to [“CKD - Chronic Kidney Disease](#)**)
 - d. Cardiovascular (**refer to [“CAD - Coronary Artery Disease](#)**)
 - e. Peripheral vascular disease (**refer to [“PVD - Peripheral Vascular Disease](#)**)
 - f. Cerebrovascular disease (**refer to [“CVA - Cerebrovascular Disease](#)**)
 - g. Acute infections
 - h. Periodontal disease
2. Describe the signs/symptoms Diabetic Ketoacidosis or Diabetic Hyperosmolar, Hypoglycemic State (HHN). For patient’s with type 1 diabetes, acute illness predisposes to Ketoacidosis.
3. Describe the signs/symptoms that the patient may experience when blood sugar is low (hypoglycemia), e.g., shakiness, dizziness, headache, hunger or nausea, blurred vision, sweating, lack of concentration, heart palpitations, irritability, unconsciousness.
4. Emphasize that optimum blood sugar, blood pressure, and lipids can reduce the risk of complications from diabetes.
5. Explain that routine laboratory testing and examinations are essential to identify the risk of complications and early treatment.

DM-CM CASE MANAGEMENT

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

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.”](#)

DM-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

DM-DP DISEASE PROCESS

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

STANDARDS:

1. Briefly describe the pathophysiology of this patient’s diabetes.
 - a. Type 2
 - i. Describe common presentations of type 2 DM.
 - ii. Explain that type 2 DM involves insulin resistance in skeletal muscle, inappropriate glucose dumping by the liver, and/or a relative insulin deficiency.
 - iii. Many of these physiologic changes begin 5-7 years prior to diagnosis and that end-organ damage may be occurring during that time.
 - iv. Explain that excessive insulin secretion by the pancreas may lead to beta cell damage and eventual insulin deficiency.
 - v. Type 2 diabetes often has a genetic component. It is not transmitted by sexual or other contact.
 - b. Type 1
 - i. Describe common presentations of type 1 DM, e.g., acute onset and ketoacidosis.
 - ii. Discuss possible reasons for pancreatic beta cell destruction.

- iii. Discuss that complete pancreatic beta cell destruction results in loss of insulin production and the need for life long insulin.
 - iv. Type 1 diabetes often has a genetic component. It is not transmitted by sexual or other contact.
2. Describe risk factors for developing diabetes.
 - i. Type 2 - family history, age, ethnicity, sedentary lifestyle, obesity.
 - ii. Type 1 - largely unknown but perhaps family history of autoimmune disorders or cystic fibrosis.
 3. Discuss the “honeymoon effect” of diabetes.
 4. Describe the signs/symptoms that the patient may experience when blood sugar is high (hyperglycemia), e.g., increased thirst, increased urination, increased hunger, unintentional weight loss, lethargy, headache, blurry vision, impaired concentration, impaired wound healing and immune response.
 5. Emphasize that there is no cure for diabetes, but it can be managed with positive lifestyle changes (healthy eating, regular physical activity, avoiding tobacco and alcohol, medication) and routine medical care.
 6. Discuss that uncontrolled diabetes may lead to debilitating complications and co-morbid conditions. **Refer to [“DM-C Complications](#).**

DM-EQ EQUIPMENT

OUTCOME: The patient/family will understand the equipment that may be used in the self-management of diabetes mellitus.

STANDARDS:

1. Discuss the specific components of this patient’s self-blood glucose monitoring, self-blood pressure monitoring, or insulin pump maintenance, as appropriate.
2. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. importance of not tampering with any medical device
3. Demonstrate the safe and proper use, care and cleaning of the equipment, and proper disposal of medical supplies, as appropriate. Participate in a return demonstration 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.

DM-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. Discuss the appropriate frequency, intensity, time, and type of activity. Set realistic goals.
5. Explain the ways to stay safe during physical activity:
 - a. Balance physical activity with meals and medications.
 - b. Check blood sugars before and after physical activity.
 - c. Start physical activity slowly, warming-up and cooling down.
 - d. Wear appropriate clothing, shoes, and socks that fit well.
 - e. Carry diabetes identification and notify someone where the patient will be exercising.
 - f. Avoid extreme weather.
 - g. Drink plenty of water before, during, and after activity.
 - h. Carry food or drink if at risk for hypoglycemia.
 - i. Stop physical activity and seek immediate medical care with pain and pressure in chest or arm, shortness of breath, nausea or vomiting, irregular heart beat, feeling very tired, feeling light-headed or faint.

DM-FTC FOOT CARE AND EXAMINATIONS

OUTCOME: The patient/family will understand the risks of skin breakdown, ulcers, and lower extremity amputation associated with diabetes.

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 and comprehensive foot exam by a trained healthcare provider. Encourage the patient to remove shoes at each clinic visit.
3. Demonstrate the proper technique for a daily home foot check by patient or support person.
4. 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.”](#)**
5. Emphasize the importance of appropriate footwear.
 - a. Desirable characteristics for shoes:
 - i. Closed shoes
 - ii. Solid soles
 - iii. Properly fitted and supportive
 - b. Undesirable characteristics of shoes:
 - i. Shoes that don't fit well
 - ii. Open toed, open heeled shoes
 - iii. Flip flops, flexible shoes, or thin soled shoes
 - iv. High heels
 - v. Pointed toes
 - c. Emphasize that going barefoot is not recommended.
 - d. Refer to podiatrist for professional evaluation and fitting as appropriate.
6. Explain that toe nails and/or ingrown toe nails must be trimmed and treated by trained medical professionals to decrease the risk for serious infection that could lead to amputation.

DM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the management of diabetes and the prevention of complications.

STANDARDS:

1. Emphasize the importance of follow-up care to monitor and adjust treatment plans. Explain that diabetes management involves many healthcare providers.
2. Discuss the procedure and process for obtaining follow-up appointments.
3. Emphasize that full participation in the treatment plan can prevent complications. This 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. Explain that the home glucose monitors and journals (food, activity, BP) are tools for evaluating the treatment plan and should be brought to every appointment.

DM-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding diabetes.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding diabetes and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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 monitoring, taking medications). Discuss the role of support systems/family in the plan.
2. Explain that home monitoring is an important tool to assist the patient in the self-management of diabetes. Discuss maintaining monitoring logs and sharing with provider at every appointment.
3. Demonstrate and receive return demonstration of home glucose monitoring and/or insulin administration as appropriate.
4. Emphasize the importance of good personal and oral hygiene. **Refer to [“HPDP-HY Hygiene](#).**

DM-KID KIDNEY DISEASE

OUTCOME: The patient/family will understand the risks of kidney damage associated with diabetes.

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”](#).
4. Discuss the need for nutrition intervention. Refer to Registered Dietitian.

DM-L LITERATURE

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

STANDARDS:

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

DM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family/caregiver will understand lifestyle adaptations for diabetes.

STANDARDS:

1. Explain that lifestyle adaptations are the key components to preventing or delaying the progression of diabetes.
2. Emphasize that nutrition and physical activity aid in achieving and maintaining a healthy weight and are critical components in addressing insulin resistance.
3. Explain that while medications may help, lifestyle adaptations are the key to improving health.
4. Explain that use of tobacco products can exacerbate the disease process and lead to complications.
5. Explain that lifestyle adaptations for diabetes patients require careful balance of nutrition, insulin and other medications, and activity. Small changes in any of these may drastically affect the health of the patient, especially in type 1 diabetes.

DM-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

DM-MNT MEDICAL NUTRITION THERAPY

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

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 eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes, carbohydrate load per meal (carbohydrate counting), and use of food labels.
3. Identify techniques or strategies for eating out, social events, traditional eating practices, and family support in managing blood sugar.

4. Explain that emotional eating from boredom, anger, frustration, loneliness, and depression can interfere with blood sugar control, as appropriate. Alternative choices should be recommended.
5. Discuss managing food intake with medication on sick days and with an exercise regime to prevent hypoglycemia.
6. Refer to registered dietitian for MNT or other local resources as appropriate.

DM-P PREVENTION

OUTCOME: The patient/family will understand major risk factors for development of type 2 diabetes. Use for only type 2 diabetes because type 1 DM has no known prevention.

STANDARDS:

1. Discuss current recommendations/importance of screening. Elevated glucose level and/or acanthosis nigricans may indicate insulin resistance.
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 diabetes.
3. Discuss the role of sedentary lifestyle and obesity in the development of type 2 diabetes. Explain that following a healthy eating plan and maintaining adequate activity levels will reduce the risk of getting type 2 diabetes.
4. Explain that gestational diabetes increases the risk of type 2 diabetes. **Refer to [“GDM - Gestational Diabetes](#)**. Breast fed babies are less likely to develop diabetes.
5. Explain that patients with are at high risk for infectious diseases. Review the current recommendations for immunizations and refer for immunization as appropriate. **Refer to [“IM - Immunizations](#)**.

DM-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.

- g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
 2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
 3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
 4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
 5. Refer for medical and psychosocial support services for any risk factor identified.

DM-PERIO PERIODONTAL DISEASE

OUTCOME: The patient/family will understand the risk of uncontrolled diabetes as it relates to dental health.

STANDARDS:

1. Explain that gum disease can contribute to poor glycemic control and cardiovascular disease.
2. Explain that the mouth (gums) contain highly vascular surface tissues that are easily damaged by poor glycemic control.
3. Explain that damage to gum tissues can result in loss of teeth and bone mass.
4. Discuss the current recommendation for annual dental examination and make appropriate referral. Explain how to access dental services.
5. Refer to [“PERIO - Periodontal Disease](#).

DM-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 its use in developing a plan to manage pain.
2. Discuss the pain management options which are available and help the patient develop a plan to monitor and manage pain.
3. Explain that lower extremity pain may be a sign of complications associated with neuropathy. Discuss with the medical provider.
4. Explain that the use of over-the-counter medications for pain can increase the risk for complications. Discuss with the medical provider.
5. Explain that all chest pain must be evaluated by the medical provider to rule out the possibility of myocardial infarction.
6. Refer to [“PM - Pain Management](#) or [“CPM - Chronic Pain.](#)

DM-S SAFETY

OUTCOME: The patient/family will understand the safety issues related to diabetes.

STANDARDS:

1. Explain the ways to stay safe during physical activity. Refer to [“DM-EX Exercise.](#)
2. Discuss proper foot care. Refer to [“DM-FTC Foot Care And Examinations.](#)
3. Discuss the signs and symptoms of hypoglycemia and hyperglycemia. Explain how to prevent and/or treat.
4. Explain that many people have Type 2 diabetes for as much as 5-7 years before diagnosis, and that end-organ damage is occurring during that time.

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.

STANDARDS:

1. Explain that uncontrolled stress can:
 - a. contribute to insulin resistance and lead to increased morbidity and mortality
 - b. interfere with the treatment of diabetes
2. 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.
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 diabetes.
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, 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 referrals as appropriate.

DM-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 (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed

- c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

DM-TX TREATMENT

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

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation with treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

DM-WC WOUND CARE

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

STANDARDS:

1. Discuss that wound healing is much faster when blood sugar is adequately controlled.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for the care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.

5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

DIA - Dialysis

DIA-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family 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 many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is able to provide guidance at the time that decisions need to be made.
3. Explain that the Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences of care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.

DIA-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family/caregiver will understand kidney location and 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 about the size of a fist.
3. 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 which regulate blood pressure, stimulate the bone marrow to produce red blood cells, and stimulate absorption of calcium by the intestine and bone.
4. Discuss bodily changes as a result of kidney failure and the impact of these changes, e.g., decrease in urine output and elimination of waste, anemia, changes in bone metabolism, cardiac effects, and overall health status.

DIA-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to dialysis.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with dialysis as a life-altering illness that requires a change in lifestyle (**refer to [“DIA-LA Lifestyle Adaptations](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with dialysis, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#)**.
6. Refer to a mental health agency or provider.

DIA-C COMPLICATIONS

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

STANDARDS:

1. Discuss the common or significant complications associated with end stage renal disease and dialysis treatment. There are many complications and may include:
 - a. Infection. Symptoms should be reported immediately, e.g., fever, pain, redness, discharge from access site.
 - b. Catheter occlusion.
 - c. Cardiovascular risks.
 - d. Disorders of bone metabolism, osteoporosis and hyperparathyroidism.
 - e. Anemia.

- f. Electrolyte and fluid imbalances.
 - g. Loss of appetite/malnutrition.
 - h. Leg cramps/pain.
 - i. Bleeding.
 - j. Dizziness.
 - k. Other metabolic problems (hyperkalemia, acidosis).
 - l. Itching
2. Discuss common or significant complications that may be prevented by full participation with the treatment plan, including diet modifications and fluid restrictions.
 3. Explain that even with proper dialysis, patients may experience fluid imbalances and that all shortness of breath, chest pain, 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.”](#)**

DIA-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed

treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

DIA-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the causes and progression of 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. It can also be hereditary or the result of acute insult to the kidney, e.g., medications, toxins, injury, infection, or decreased renal perfusion.
2. Discuss signs/symptoms and usual progression of end stage renal disease.
3. Explain that 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 following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.
4. Create a backup plan for electrical equipment in the event of a power-outage.

DIA-EX EXERCISE

OUTCOME: The patient/family/caregiver will understand the role of physical activity for patients on dialysis.

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, more efficient dialysis, 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.

DIA-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

DIA-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding dialysis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding dialysis and dealing with issues.
2. Provide the help line phone number or Internet address (URL), such as <http://kidney.niddk.nih.gov/KUDiseases/pubs/choosingtreatment/index.aspx>

DIA-HM HOME MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the home management for a patient on dialysis.

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.
4. Discuss the storage needs of peritoneal equipment and dialysate.
5. Discuss hygiene habits that are specially pertinent to catheter care or peritoneal dialysis exchanges.
 - a. Emphasize the importance of using aseptic technique with peritoneal catheter care and during exchanges.
 - b. Emphasize the importance of keeping the central line catheter clean, dry, and avoid touching to prevent infection.

DIA-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to dialysis.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

6. Emphasize the importance of using aseptic technique with peritoneal catheter care and during exchanges. Emphasize the importance of keeping the central line catheter clean, dry, and avoid touching to prevent infection.

DIA-L LITERATURE

OUTCOME: The patient/family/caregiver will receive literature regarding hemodialysis or peritoneal dialysis.

STANDARDS:

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

DIA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family/caregiver will understand the lifestyle adaptations necessary for dialysis.

STANDARDS:

1. Review the lifestyle aspects/changes that the patient has control over: hygiene, 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 to prevention or treatment of the disease is a healthier, lower risk lifestyle.
3. Review the community resources available to assist the patient in making lifestyle changes. Refer as appropriate.
4. Discuss the time management/transportation issues involved in dialysis, e.g., scheduling, availability of dialysis centers, taking medications/food for the trip.

DIA-M MEDICATIONS

OUTCOME: The patient/family/caregiver will understand the use of medications and dialysis.

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/dialysis, 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 medication needs may change with dialysis.

DIA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for dialysis.

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 role of nutrition and need for diet modifications as part of the management of dialysis.

STANDARDS:

1. Emphasize the importance of full participation in the nutrition plan.
2. Discuss the nutritional modifications for end stage kidney disease as appropriate. Typical dietary restriction may include fluids, protein types, potassium, sodium, and phosphorus.
3. Explain that lack of appetite for red meats, fish, poultry, eggs, or other protein foods is common. Work with patient to plan adequate protein and calorie intake.
4. Discuss maximum fluid gain. Teach patient how to manage fluids in foods and free liquids.

5. Discuss current nutritional habits. Assist the patient in identifying unhealthy eating behaviors that could interfere with the nutritional plan. Provide information about dining away from home or home delivered meals.
6. Refer to a Registered Dietitian as appropriate.

DIA-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of developing end stage renal disease requiring dialysis. The patient/family will understand ways to prevent complications of dialysis.

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. **Refer to [“CKD - Chronic Kidney Disease](#).**
2. Emphasize the importance of using aseptic technique with peritoneal catheter care and during exchanges.
3. Emphasize the importance of keeping the central line catheter clean, dry, and avoid touching to prevent infection.
4. Emphasize the importance of assessing vascular access, e.g., feeling for thrill, checking for numbness, bleeding, and redness.

DIA-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed dialysis procedure(s).

STANDARDS:

1. Discuss the indications, risks, and 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review

- e. measures to prevent surgical site infections
- 5. Discuss pain management as appropriate.

DIA-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](#).**
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.

DIA-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results

- b. follow-up tests may be ordered based on the results
- c. how results will impact or effect the treatment plan
- d. recommendations based on the test results

DIA-TX TREATMENT

OUTCOME: The patient/family will understand the option of Hemodialysis and Peritoneal dialysis.

STANDARDS:

1. Explain Hemodialysis (HD) and the treatment plan.
 - a. HD is artificial filtering (hemodialyzer) of blood by a machine to remove waste products and water from the body.
 - b. Before beginning HD, a minor surgical procedure such as arteriovenous fistula, graft, cannula, femoral or subclavian catheter is necessary to provide access to the blood.
 - c. The types of HD: Home hemodialysis, Self-Care hemodialysis, and In-center or staff-assisted hemodialysis. The average treatment last 3 to 5 hours 3 times per week depending on the type of HD used.
2. Explain Peritoneal Dialysis (PD) and the treatment plan.
 - a. PD involves the removal of body waste products and water within the peritoneal cavity by using a dialysis solution called a dialysate. The dialysate containing a high-dextrose concentration which is instilled through the peritoneal catheter into the peritoneum, where diffusion carries waste products from the blood through the peritoneal membrane and into the dialysate.
 - b. A catheter is surgically implanted in the abdomen and into the peritoneal cavity and used as the access site for PD.
 - c. There are several types of PD: Intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD), and continuous ambulatory peritoneal dialysis (CAPD). Explain that the average treatment time is dependent on the type of PD used.
3. Each daily session is dependent on the type of peritoneal dialysis used:
 - a. 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.
 - b. 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.

- c. 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.
4. Discuss kidney transplant as a treatment option:
 - a. Kidney transplantation is completed in end stage kidney disease when the glomerular filtration rate drops to 10 mL/min.
 - b. Persons older than 50 years of age with poor health or history of cancer often can not receive a transplant.
 - c. Children must receive an evaluation from a pediatric renal transplant team prior to receiving a transplant or being considered as a donor.
 - d. After a renal transplant, the patient has a functioning donor kidney. Medications and regular medical evaluations will usually be required to prevent rejection.
 - e. 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.
 - f. Patients with co-morbidities leading to initial kidney failure must be instructed to follow all prescribed regimens to avoid subsequent kidney failure.
 - g. There is a possibility that a donor kidney may fail or be rejected even under ideal conditions.
5. Emphasize the importance of active participation by the patient/family in the development and adherence to the treatment plan.
6. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.

DCH - Discharge from Hospital

DCH-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components as it relates to discharge from the hospital.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with an acute illness or injury, chronic disease, or debilitating condition as a life-altering illness that requires a change in lifestyle. **Refer to [“DCH-LA Lifestyle Adaptations”](#)**. Discuss the challenges of being discharged without adequate resources or support.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with an acute illness or injury, chronic disease, or debilitating condition, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#)**.
6. Refer to a mental health agency or provider.

DCH-CM CASE MANAGEMENT

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

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”](#)**.

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

DCH-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

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. Emphasize the importance of follow-up care following hospitalization.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

DCH-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding hospital discharge.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding hospital discharge and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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-IB INSURANCE AND BENEFITS

OUTCOME: The patient/family will understand healthcare services and resources available as it relates to insurance and benefits.

STANDARDS:

1. Explain that many individuals qualify for direct payments and/or reimbursement for health care and related costs from certain programs.
2. Explain that direct payments include services that:
 - a. Are provided at the health care facility at no cost to the patient.
 - b. Are provided at other health care facilities through contract health services.
 - i. Contract services are services that Indian Health Systems facilities cannot always provide.
 - ii. They may require a referral to non-Indian Health Systems facilities.
3. Explain that in addition to Indian Health Systems, the other available programs include:

- a. Medicare: a national healthcare program that covers people 65 years of age and older, individuals younger than 65 who are disabled or with end stage renal disease, and retired railroad employees.
 - i. Medicare Part A: Inpatient hospital services, skilled nursing facilities, home health and hospice care.
 - ii. Medicare Part B: Outpatient hospital services, doctors, certain medical equipment and other items not covered under Part A.
 - iii. Medicare Part D: Prescription medication and Medication Therapy Management (MTM) service coverage.
- b. Social Security Disability Insurance
- c. State Children's Health Insurance Programs (SCHIP)
- d. Supplemental Security Income (SSI)
- e. Veterans Administration (VA)
- f. Medicaid that provides resources to help pay for medical and long-term care assistance
- g. Private Health Plans
- h. Women, Infants, and Children (WIC)
- i. State/federal aid for disabled children
- j. Temporary Assistance for Needy Families (TANF)
4. Explain that a Benefits Coordinator is knowledgeable about federal and state programs and is a resource to help a patient determine program eligibility
5. Review and explain applications for identifiable services.
6. Explain that Indian Health Systems services can be enhanced due to revenue collected when a patient enrolls in additional health care resource.

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 the patient/family with literature on the discharge diagnosis and therapeutic plan.
2. Discuss the contents of the literature.

DCH-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family 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 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

DCH-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed after hospital discharge.

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/family will understand the need for balanced nutrition and plan for the implementation of dietary modification following hospital discharge.

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.

STANDARDS:

1. Explain the basic plan of care for the patient, including the following: as appropriate:
 - 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 PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

DCH-REF REFERRAL

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

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 utilizing 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. 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 understand 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.
4. Explain the patient's right to dispute discharge if the patient does not feel ready.

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"](#).**

DCH-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test

2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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.

DISSD - Dissociative Disorders

DISSD-C COMPLICATIONS

OUTCOME: The patient/family will understand the common complications related to dissociative disorders.

STANDARDS:

1. Explain that individuals diagnosed with dissociative disorders sometimes report depression, dysphoria, grief, shame, guilt, psychological stress, sexual dysfunction, impulsivity, impairment in work and interpersonal relationships, self-mutilation, aggressive impulses, and suicidal impulses and acts.
2. Explain that individuals diagnosed with Dissociative Identity Disorder (DID) often have co-morbid diagnoses of Posttraumatic Stress Disorder (**refer to [“PTSD - Posttraumatic Stress Disorder](#)**) and Major Depressive Disorder (**refer to [“DEP - Depressive Disorders](#)**). Dissociative disorders may also have symptoms that meet the criteria for Substance-Related Disorders (**refer to [“AOD - Alcohol and Other Drugs](#)**), other mood disorders, personality disorders (**refer to [“PERSD - Personality Disorder](#)**), sexual disorders, eating disorders, and sleep disorders.

DISSD-CM CASE MANAGEMENT

OUTCOME: The patient/family will understand the importance of integrated case management in treating dissociative disorders.

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](#).**

DISSD-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 health and wellness.

STANDARDS:

1. Discuss any cross-cultural perspectives. Dissociative states are a common and accepted expression of cultural activities or religious experiences in many societies, and are not considered pathological.

2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
3. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

DISSD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of the dissociative disorders under consideration.

STANDARDS:

1. Explain that the essential features of the dissociative disorders is a disruption in the usual integrative functions of consciousness, memory, identity, or perception of the self and environment, as appropriate:
 - a. **Dissociative Identity Disorder (DID)**, formerly Multiple Personality Disorder:
 - i. It is the most severe type of dissociation.
 - ii. It is characterized by the presence of two or more distinct identities or personality states that recurrently take control of the individual's behavior.
 - iii. It is usually accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
 - b. **Dissociative Amnesia** is characterized by:
 - iv. a retrospective series of memory gaps, i.e., repressed memories
 - v. by the inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness
 - c. **Dissociative Fugue** is characterized by:
 - vi. sudden, unexpected travel away from home or one's customary place of work
 - vii. the inability to recall one's past or travel
 - viii. confusion about personal identity or the assumption of a new identity
 - d. **Depersonalization Disorder** is characterized by a persistent or recurrent feeling of being detached from one's mental processes or body that is accompanied by intact reality testing.

- e. **Dissociative Disorder Not Otherwise Specified (NOS)** is included for coding disorders in which the prominent feature is a dissociative symptom, but which do not meet the criteria for any specific dissociative disorder.
2. Discuss the clinical course of the specific disorder under consideration, all of which have episodes of dissociation lasting from hours to months.
 - a. Often dissociative episodes follow stressful or traumatic life events in adulthood, especially in dissociative fugue and amnesia, and may remit spontaneously or gradually when removed from the traumatic event.
 - b. The first symptom presentation in DID usually begins by age 6 or 7, and has fluctuating, chronic, and recurrent clinical course.
3. Discuss the patient's personal history, which presumably includes multiple incidents of physical, sexual, and emotional abuse at the root of the dissociations, among other traumatic and overwhelming life events, especially with those individuals diagnosed with DID.
4. Explain that dissociative symptoms are also often present in Posttraumatic Stress Disorder, Acute Stress Reaction, and somatization disorders, but a dissociative diagnosis is not given if the symptoms occur exclusively during the course of one of these disorders.
5. Explain that patients diagnosed with DID report a variation in physiological functions across identity states, e.g., differences in visual acuity, pain tolerance, symptoms of asthma, response of blood glucose to insulin, and sensitivity to allergens and medications.
6. Explain that the dissociative disturbance must not be due to the direct effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication), or a general medical condition (e.g., complex partial seizures).

DISSD-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in maintaining health with dissociative disorders.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

DISSD-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

DISSD-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

DISSD-L LITERATURE

OUTCOME: The patient/family will receive literature about the dissociative disorder or symptoms.

STANDARDS:

1. Provide the patient/family with literature on the dissociative disorder or symptoms.
2. Discuss the content of the literature.

DISSD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for coping with dissociation.

STANDARDS:

1. Discuss lifestyle adaptations specific to dissociation, depending on the severity of symptoms.
2. Discuss that the family may also require lifestyle adaptations to care for the patient, including the application of safety measures.
3. Discuss work, family, diet, and exercise adaptations that will be necessary due to the nature of medications that can cause sedation and/or cravings for sweet food.
4. Refer to community services, resources, or support groups, as available.

DISSD-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 that medications are not usually prescribed for treating dissociation, but rather is used to treat co-occurring conditions.
 - b. Explain that medication efficacy has been shown to vary, even on a daily basis, in individuals diagnosed with Dissociative Identity Disorder due to alterations in consciousness or the presence of different identities.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

DISSD-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of dissociative disorders.

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. Emphasize that full participation and follow-up is critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain that the therapist and the patient/family will establish goals and duration of therapy together.

DISSD-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to dissociative disorders and co-occurring conditions.

STANDARDS:

1. Discuss/review the safety plan, including the no-harm contract and emergency procedures, due to the risk of suicide, homicide, or other risky/dangerous behaviors.
2. Discuss the importance of talking about any new dissociative experiences with the mental health providers at each session, and ways of tracking the progression and/or severity of the symptoms.
3. Review the local resources and phone numbers, including the police that may be utilized during a crisis, and may assist in transportation and safety compliance.

DISSD-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in coping with dissociative disorders.

STANDARDS:

1. Explain that unmanaged stress can precipitate or have an adverse effect on dissociative symptoms, as well as other co-occurring conditions.
2. Explain the role of effective stress management in preventing and/or abating mood changes and/or decompensation.
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.

DISSD-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

DISSD-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options for dissociative disorders.

STANDARDS:

1. Explain that a combination of psychotherapy and medication interventions usually has better results than therapy or medication alone. Explain that the patient has a right to choose either option or both, and that the patient's active participation in the treatment decisions is critical to a good outcome.

2. Explain that therapists have different styles and orientations for treating dissociative disorders, and that no one style has been shown to be superior:
 - a. Eye Movement Desensitization and Reprocessing (EMDR) has been especially effective in eliminating or reducing symptoms of dissociation and co-occurring disorders. EMDR may not be indicated in early stages of treatment for Dissociative Identity Disorder (DID), or where a history of psychosis is present.
 - b. Long-term psychotherapy has been demonstrated to be effective in treating DID, which may entail:
 - i. Building a strong therapeutic alliance with most or all alternate identities (often called “alters”)
 - ii. Raising the patient’s awareness of the presence and role of all/most of the alters
 - iii. Improving communication and cooperation among alters
 - iv. Teaching patient responsibility for and/or the meaning behind the behaviors of any alter in the body, while avoiding blame for negative actions
 - v. Helping patients to verbalize traumatic experiences
 - vi. Completing trauma work
3. Explain that medications may be prescribed intermittently or throughout the treatment process. Explain that decisions about timing and duration of medication will be made jointly by the provider(s) and the patient.
 - a. Explain that medications are not usually prescribed for treating dissociation, but rather is used to treat co-occurring conditions.
 - b. Explain that medication efficacy has been shown to vary, even on a daily basis, in individuals diagnosed with Dissociative Identity Disorder due to alterations in consciousness or the presence of different identities.
4. Explain the importance for patients to learn to talk about the traumas in the safe context of the therapeutic environment. Support groups with patients who have experienced similar traumas may be useful.

DIV - Diverticulitis/Diverticulosis

DIV-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

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. Discuss that common signs include lower abdominal cramping, abdominal distention fever, malaise, and hemorrhage. Emphasize the importance of immediate follow-up.
3. 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 fiber.

3. Explain that diverticulosis develops in nearly 50% of persons over age 60, but only a small percentage develops diverticulitis.
4. Explain that symptoms of diverticulitis may range from mild abdominal soreness and cramps with “gas” and low grade fever, to severe cramping and pain accompanied by fever, chills, nausea, abdominal rigidity, and massive hemorrhage.
5. Inform the patient that diverticulitis may be acute or chronic.

DIV-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

DIV-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

DIV-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding diverticulitis/diverticulosis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding diverticulitis/diverticulosis and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for prevent complications of diverticulitis/diverticulosis 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. Discuss that the family may also require lifestyle adaptations to care for the patient.
4. Review the community resources available to assist the patient in making lifestyle changes. Refer as appropriate.

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 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

DIV-MNT MEDICAL NUTRITION THERAPY

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

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 the role of nutrition and diverticulitis.

STANDARDS:

1. Assess current nutritional habits and assist the patient/family in developing appropriate meal plans. Refer to a Registered Dietitian, as appropriate.
2. Emphasize the importance of water in maintaining fluid balance and preventing constipation.
3. Explain that bulk can be added to stools by eating foods high in fiber and low in sugar. Encourage fruits and vegetables with high fiber content (seedless grapes, fresh peaches, carrots, lettuce) and avoidance of indigestible fiber, such as celery and corn.

4. Advise the patient/family to avoid extremely hot or cold foods and fluids, because they may cause flatulence. Alcohol, which irritates the bowel, should be avoided.
5. Stress the importance of thoroughly chewing all foods.

DIV-P PREVENTION

OUTCOME: The patient/family will understand the possible prevention of diverticulitis and/or diverticulosis.

STANDARDS:

1. Explain that the etiology of diverticulitis/diverticulosis is unclear, but an appropriate diet (low fat, high fiber) 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-PRO PROCEDURES

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

STANDARDS:

1. Discuss the indications, risks, and 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent

- b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

DIV-TE TESTS

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

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

DIV-TX TREATMENT

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

STANDARDS:

1. Discuss the specific treatment plan, which may include the following:
 - a. During acute episodes, nothing by mouth. IV fluid and nutritional support may be necessary in order to rest the bowel.
 - b. Liquid or bland diet during the less acute phase, followed by 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/colostomy.
2. Advise the patient to avoid activities that raise intra-abdominal pressure, e.g., straining during defecation, lifting, coughing.
 3. Discourage smoking and drinking alcohol, because they irritate the intestinal mucosa.

DVP - Domestic Violence, Perpetrator

DVP-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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

DVP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand that domestic violence is a chronic and preventable condition involving a specific pattern of behaviors, beliefs, attitudes, and feelings.

STANDARDS:

1. Explain that domestic violence can become a chronic condition and has its roots in low-self worth, fears of abandonment or being alone, and can be seeded in early childhood or adolescence. Examples can be: real or imagined abandonment by caretakers, witnessing violence within the family, being a victim of abuse or neglect, having a emotionally-unavailable parent (alcoholic or depressed).
2. Explain co-dependency as it relates to domestic violence. Discuss the patient's and family members' attitudes toward their dependency.
3. Discuss the patient/family member's abusive/violent/controlling behavior and/or pattern of victimization.
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

DVP-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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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. Discuss the plan of action for situations that are dangerous or life threatening.

DVP-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.

DVP-L LITERATURE

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

STANDARDS:

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

DVP-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. Explain that the natural course of domestic violence is one of escalation and that without intervention it will not resolve.
4. Discuss how to identify “red flag” behaviors in current or potential partners:
 - a. Excessive jealousies and accusations of cheating
 - b. Monitoring time and excessive questioning
 - c. Alienation from friends and family
 - d. Verbal abuse (criticizing, name calling)
 - e. Rummaging through personal belongings
 - f. Other excessive controlling behaviors
5. Develop a plan of care to avoid violent relationships.

DVP-PSY PSYCHOTHERAPY

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

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

DVP-S SAFETY

OUTCOME: The patient, family members, and other victims will understand the pattern of domestic violence, will make a plan to end the violence, will develop a plan to ensure safety of everyone in the environment of violence, and will 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 [“DVP-DP Disease Process.”](#)**
3. Assist to develop a plan of action that will insure safety of all people in the environment of violence.

DVP-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, 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.

DVP-TX TREATMENT

OUTCOME: The patient/family will understand the co-morbidity of domestic violence with other conditions and the potential long-term interventions which may include psychotherapy, medication, and support groups.

STANDARDS:

1. Review the nature of domestic violence as a treatable disease.
2. Explain that both the patient and the family need to acknowledge and take responsibility for their respective contributions to the family dysfunction.

3. Review the treatment options available, including individual and group therapy as well as the potential risk or contraindications of other options, such as family or couples counseling.
4. Discuss the importance of individual or group psychotherapy in:
 - a. addressing co-dependency
 - b. changing negative cognitions/low self esteem
 - c. healing precipitating childhood and adulthood factors of past abuse, neglect, and abandonment
 - d. treating associated conditions, such as depression and posttraumatic stress disorder

DVV - Domestic Violence - Victim

DVV-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications that can result when domestic violence is not addressed.

STANDARDS:

1. Explain that domestic violence usually progresses over time and may develop into the serious physical and mental problems in the victim. Explain that the violence often escalates into experiences of “red outs” that result in serious injuries and death.
2. Explain that repeated threats, assaults, and controlling behaviors are often responsible for the development of mental disorders, including depression, anxiety (refer to [“DEP - Depressive Disorders”](#)), posttraumatic stress disorder (refer to [“PTSD - Posttraumatic Stress Disorder”](#)), and personality disorders (refer to [“PERSD - Personality Disorder”](#)).
3. Explain that children who witness violence in the home are additionally in danger of developing mental disorders, and have an increased likelihood of becoming a victim and/or perpetrator in their future relationships.

DVV-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

DVV-DP DISEASE PROCESS

OUTCOME: The patient/family will understand that domestic violence is a chronic and preventable condition involving a specific pattern of behaviors, beliefs, attitudes, and feelings.

STANDARDS:

1. Discuss the abusive, violent, and controlling behavior, and/or the pattern of victimization.

2. Explain co-dependency as it relates to domestic violence. Discuss the patient's ability to opt-out of the relationship, e.g., safe houses.
3. Discuss the role of alcohol and substance abuse as it relates to domestic violence.
4. Explain that the natural course of domestic violence is one of escalation and that without intervention it will not resolve. The progression of abuse may be conceptualized as including:
 - a. Early Stage: Excessive jealousies, accusations of cheating, excessive questioning about whereabouts and companions, monitoring time, and/or alienation from friends and family.
 - b. Middle Stage: In addition to the previous stage, one may experience verbal abuse, criticism, threats to hurt or kill, or threats of suicide.
 - c. Late Stage: In addition to previous stages, may also include all forms of physical abuse, including slapping, pushing, punching, kicking, choking, sexual abuse, use of weapons, and/or blocking escape.
 - i. Explain that the violence often escalates into experiences of "red outs" that result in serious injuries and death.
 - ii. These behaviors that could not have been anticipated by the perpetrator's previous behavior.

DVV-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

DVV-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help/crisis intervention line.

STANDARDS:

1. Explain that a help/crisis intervention line may assist in dealing with an immediate crisis.

2. Provide the help/crisis line phone number and hours of operation.
3. Explain how the help/crisis line works and what can be expected from calling and participating in the services.

DVV-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, including a list of any private and public community agencies that can provide or arrange for assessment and care of individuals involved in domestic violence.
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

DVV-L LITERATURE

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

STANDARDS:

1. Provide the patient/family with literature on domestic violence, which may include safety procedures (**refer to [“DVV-S Safety”](#)**), and a list of private and public treatment programs and shelters.
2. Discuss the content of the literature.

DVV-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, regardless of the victim’s behavior, environmental stressors, physiologic changes, shifts in mood, and illnesses may precipitate violent behavior in persons who are predisposed to violent behaviors.
3. Discuss how to identify “red flag” behaviors in current or potential partners:
 - a. Excessive jealousies and accusations of cheating

- b. Monitoring time, such as driving time and delays
 - c. Excessive questioning about whereabouts and companions
 - d. Alienation from friends and family
 - e. Verbal abuse (criticizing, name calling)
 - f. Rummaging through personal belongings
 - g. Other excessive controlling behaviors
4. Develop a plan of care to avoid violent relationships.

DVV-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of domestic violence.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the parent/caretaker/patient that the therapist parent/caretaker/patient will establish goals and duration of therapy together.

DVV-RP MANDATORY REPORTING

OUTCOME: The patient/family will understand the process of mandatory reporting.

STANDARDS:

1. Emphasize importance of reporting suspected domestic violence to the proper law enforcement and child welfare/protective agencies and the patient's healthcare provider.
2. Explain that mandatory reporting is necessary to ensure the safety of all victims.
3. Explain that requirements for mandatory reporting vary by state. Some states require reporting for "reasonable cause to believe" while others require reported for "known or suspected" domestic violence.
4. Explain that states may require healthcare providers, mental healthcare providers, teachers, social workers, day care providers, and law enforcement personnel to report suspected domestic violence.

5. Explain that failure to report such information may result in criminal or civil liability for the provider.

DVV-S SAFETY

OUTCOME: The patient/family will understand the safety issues as they relate to domestic violence.

STANDARDS:

1. Be sure family members and other victims are aware of shelters and other support options available in their area. Offer a list of resources and make referrals as appropriate.
2. Assist to develop a plan of action that will insure safety of all people in the environment of violence.
3. Explain the need for the family to develop a safety plan if and when the victim decides to leave the home.

DVV-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, 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.

DVV-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options for domestic violence.

STANDARDS:

1. Review the treatment options available, including individual and group therapy, as well as the potential risk or contraindications of other options, such as family or couple's counseling.
 - a. Explain that additional treatment may be needed for co-morbid conditions as a result of repeated abuse and violence, including PTSD and depression.
 - b. Explain that psychotropic medications may be prescribed in combination with psychotherapy for co-morbid conditions, including insomnia, depression, and anxiety.
2. Explain the need to acknowledge the repeated cycle of violence and request help. Explain that it is unrealistic to expect change without help, even when both partners desire the change.
3. Explain that violence often cannot be avoided within many relationships by changing the victim's behaviors alone.
 - a. Explain that the victim is not responsible for the violence, and that other options for conflict resolution and taking care of the family may be learned.
 - b. Explain the perpetrator will not be able to end the violence without help despite any changes in the victim's behavior.
4. Explain that the treatment plan will be made by the patient and treatment team after reviewing available options. Explain that treatment for domestic violence may vary according to the patient's life circumstances, severity of the condition, the patient's participation in the choices, and available resources.

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, that receive blood from the lungs and body and contract at the same time to force blood into ventricles. Normally, ventricles and atria contract at the same time to force blood to the lungs and body.
2. Explain that specialized pacemaker tissue in the heart stimulates the heart to contract. Other tissues conduct the impulses through the heart.
3. Explain that when there is a malfunction, the normal pacemaker may not work properly, other tissues may initiate abnormal impulses or the impulses may not be conducted properly. Explain that any of these may cause abnormal heart rhythms.

DYS-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to dysrhythmia.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with dysrhythmia as a life-altering illness that requires a change in lifestyle (**refer to [“DYS-LA Lifestyle Adaptations](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with dysrhythmia, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#)**.
6. Refer to a mental health agency or provider.

DYS-C COMPLICATIONS

OUTCOME: The patient/family will understand 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, fainting, stroke, heart failure, sudden death.
2. List the symptoms that should be reported immediately, e.g., shortness of breath, dizziness, chest pain, increased fatigue, loss of consciousness.
3. Discuss the complications of anticoagulant therapy if appropriate.

DYS-DP DISEASE PROCESS

OUTCOME: The patient/family 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. Relate how the dysrhythmia occurs.
2. Describe the symptoms of the dysrhythmia. 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.
3. 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.

DYS-EX EXERCISE

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

STANDARDS:

1. Discuss the medical clearance issues for physical activity in patients with cardiac conditions.
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.

DYS-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

DYS-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding dysrhythmia.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding dysrhythmia and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

DYS-L LITERATURE

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

STANDARDS:

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

DYS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adaptations necessary to prevent complications of dysrhythmias 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.

DYS-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of the 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

DYS-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The parent/family will understand the specific nutritional intervention(s) needed in dysrhythmias.

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.

DYS-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 dysrhythmia. Emphasize the importance of full participation in the nutrition plan.
3. Discuss the current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.

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. Discuss the indications, risks, and 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

DYS-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. **Refer to [“AF-REF Referral Process”](#).**
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

DYS-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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, ablation, pacemaker, implantable defibrillator).
4. Discuss anticoagulant therapy as appropriate.

E**ECC - Early Childhood Caries****ECC-AP ANATOMY AND PHYSIOLOGY**

OUTCOME: The parent/family will understand the anatomy/physiology of early childhood caries (ECC).

STANDARDS:

1. Discuss anatomy/physiology as it applies to early childhood caries.
2. Discuss the changes to anatomy/physiology as a result 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 early childhood caries (ECC).

STANDARDS:

1. Review the consequences of severe tooth decay in primary teeth:
 - a. abnormal eruption or caries of permanent teeth
 - b. pain
 - c. infection
 - d. tooth loss (primary teeth act as holding spaces for the eruption of permanent teeth)
 - e. speech problems
 - f. altered eating and nutritional intake
 - g. aesthetics
2. Review that surgical intervention may be necessary to treat ECC. Review any surgical considerations and the health risks of general anesthesia.

ECC-DP DISEASE PROCESS

OUTCOME: The parent/family will understand early childhood caries (ECC).

STANDARDS:

1. Review the current factual information regarding the causes of ECC. ECC is a preventable, infectious, transmissible disease caused by acid-producing bacteria.

2. Discuss how dental disease can be passed from parent to infant through spread of transmissible infections during activities such as, placing pacifier in the parent's mouth prior to placing in the infant's mouth and parental pre-chewing of food.
3. Discuss the role of sugar, bottle propping, and prolonged bottle use.
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. Emphasize the importance of follow-up care (including dental well child visits and preventive care).
2. Discuss the procedure and process for obtaining follow-up appointments.
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, 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-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to early childhood caries.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.

- b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
- c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of daily dental hygiene, with attention to brushing and flossing. Discuss wiping the baby's gums and teeth with a moist cloth after each bottle feeding.
3. Discuss the need for parental dental hygiene because dental disease can be passed from parent to infant, e.g., by placing the pacifier in the parent's mouth prior to giving to the infant or by parental pre-chewing of food.
4. Discuss hygiene as part of a positive self image.
5. Discuss cleaning procedures for bottles and bottle nipples.

ECC-L LITERATURE

OUTCOME: The parent/family will receive literature about early childhood caries (ECC).

STANDARDS:

1. Provide the 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:
 - a. no bottles in the bed
 - b. no propping of bottles
 - c. begin introducing cup at 6 months of age
 - d. weaning at 12 months of age
3. Remind parents/family/caregivers that breastfeeding does not cause dental caries. Refer to [**BF - Breastfeeding**](#).
4. Discourage giving child any sugar or sweetened beverages in bottle.
5. Discuss how dental disease can be passed from parent to infant through spread of transmissible infections during activities such as, placing pacifier or bottle nipple in the parent's mouth prior to placing in the infant's mouth, feeding child with

utensils that have been in the parent's mouth, kissing child on the mouth, and parental pre-chewing of food.

ECC-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

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 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 formula, fruit juices, or other sweet liquids may increase the risk for dental caries. Discourage giving child any sugar or sweetened beverages in bottle.

ECC-P PREVENTION

OUTCOME: The parent/family will understand how to prevent early childhood caries (ECC) with healthy lifestyle behaviors.

STANDARDS:

1. Review age appropriate oral hygiene.
2. Discuss additional methods of prevention, including fluoride supplementation (toothpaste, mouth rinses, drops), water fluoridation, fluoride varnish application. Explain the use of xylitol (toothpaste, rinse, and chewing gum, as age appropriate) to reduce bacteria from creating the acids that damage teeth for caries prevention.
3. Explain 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.
6. Discuss the application of dental sealants (thin plastic coating) to the grooves on the chewing surface of molars to protect from the development of dental caries, as age appropriate.

ECC-PM PAIN MANAGEMENT

OUTCOME: The parent/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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. 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 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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management and anxiolytics as appropriate.

ECC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)

- e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
- a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

ECC-TX TREATMENT

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

STANDARDS:

1. Discuss indications for returning to the provider, e.g., bleeding, persistent or increasing pain, and fever.
2. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation with treatment plan.
3. Discuss therapies that may be utilized.
4. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment

EAT - Eating Disorders

EAT-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to eating disorders.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with eating disorder as a life-altering illness that requires a change in lifestyle (refer to [“EAT-LA Lifestyle Adaptations”](#)).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with eating disorder, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. Refer to [“AOD - Alcohol and Other Drugs”](#).
6. Refer to a mental health agency or provider.

EAT-C COMPLICATIONS

OUTCOME: The patient/family will understand the possible complications associated with eating disorders.

STANDARDS:

1. Explain that individuals diagnosed with eating disorders often develop other problems associated with emotional stress (and which may sometimes precede the eating disorder), including:
 - a. Low self-esteem and other depressive symptoms or mood disorders (refer to [“DEP - Depressive Disorders”](#)), often including social withdrawal/isolation, insomnia, irritability, and diminished interest in sex.
 - b. Obsessive-Compulsive features (refer to [“OCD - Obsessive-Compulsive Disorder”](#)), usually related to preoccupations with food and exercise.
 - c. Anxiety Disorders or symptoms, such as fear of social situations (refer to [“PHOB - Phobias”](#)) or Posttraumatic Stress (refer to [“PTSD - Posttraumatic Stress Disorder”](#)).

- d. Substance Abuse or Dependence (**refer to [“AOD - Alcohol and Other Drugs”](#)**), especially regarding alcohol or stimulants, which occurs in about one third of individuals with Bulimia.
 - e. Food insecurity due to lack of food.
2. Explain that recurrent vomiting eventually leads to several physical/ medical complications, including, but not limited to:
 - a. nutritional deficiencies
 - b. dental disorders
 - c. fluid and electrolyte imbalances
 - d. menstrual irregularities and endocrine disorders
 - e. growth and developmental abnormalities
 - f. esophageal tears and gastric rupture
 3. Explain that complications of eating disorders may lead to death.
 4. Explain that some eating disorders may lead to overweight or obesity.
 5. Explain that depression and suicidal ideation (**refer to [“SI - Suicidal Ideation and Gestures”](#)**) are often associated with eating disorders.

EAT-CM CASE MANAGEMENT

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

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”](#).**

EAT-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.

2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

EAT-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of the eating disorder under consideration.

STANDARDS:

1. Explain the essential features and symptoms of the specific disorder under consideration, all of which include a severe disturbance in eating behavior and perception of body shape and weight:
 - a. **Anorexia Nervosa** is characterized by a refusal to maintain a minimally normal body weight for age and height.
 - b. **Bulimia Nervosa** is characterized by repeated episodes of binge eating and inappropriate compensatory behaviors.
 - c. **Binge Eating Disorder** is characterized by recurrent episodes of binge eating without the inappropriate compensatory behaviors.
 - d. **Eating Disorder Not Otherwise Specified (NOS)** is also characterized as a severe disturbance in eating behavior which does not meet the criteria for the specific eating disorders above, although most of the symptoms are present.
2. Explain that associated features of some eating disorders include intense fear of gaining weight or becoming fat, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the eating disorder.
3. Explain that the course of eating disorders can be chronic or intermittent, leading to full recovery for some, while demonstrating fluctuating patterns of weight gains and relapse for others.

EAT-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in the development and course of eating disorders.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Explain the risks of excessive exercise as an inappropriate compensatory behavior.
4. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.

5. Discuss the appropriate frequency, intensity, time, and type of activity.
6. Refer to community resources as appropriate.

EAT-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

EAT-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding eating disorders.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding eating disorders.
2. Provide the help line phone number or Internet address (URL).

EAT-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.

- b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

EAT-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, such as referral to a specialized Eating Disorders clinic.
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

EAT-L LITERATURE

OUTCOME: The patient/family will receive literature about eating disorders.

STANDARDS:

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

EAT-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for coping with an eating disorder or a family member with the diagnosis.

STANDARDS:

1. Discuss lifestyle adaptations specific to monitoring one's own eating habits and making healthy social and recreational choices.
2. Discuss that family may also require lifestyle adaptations to care for the patient, and to avoid enabling or neglectful behavior.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

EAT-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy for symptoms and conditions associated with or comorbid to eating disorders.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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 the abuse of over-the-counter medications, such as laxative, diet aids, and diuretics, is common and should be discouraged.

EAT-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for eating disorders.

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.

EATK-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to eating disorders.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

EAT-P PREVENTION

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

STANDARDS:

1. Explain that eating disorders arise from a variety of physical, emotional/stressful, social, and familial issues, all of which need to be addressed for effective prevention, including:
 - a. Objectification and other forms of mistreatment of women to prevent the obsession with appearance and shame about one's body.
 - b. Cultural obsession with slenderness as a physical, psychological, and moral issue, e.g., video games and media.
 - c. The impact of rigid gender roles of men and women in our society.
 - d. Peer pressure/bullying are contributing factors.
2. Discuss how families may teach their children to resolve their problems in healthy ways other than by manipulating their meals and weight.
3. Discuss the importance of attending primary prevention programs early for children at risk, before children learn to feel bad about their bodies.
4. Discuss that the prevention strategies include:
 - a. The development of people's self-esteem and self-respect in a variety of areas (school, work, community service, hobbies, etc.) that transcend physical appearance.

- b. Prevention programs for schools, community organizations, etc., that are coordinated with opportunities for participants to speak confidentially with a trained professional with expertise in the field of eating disorders.
 - c. Referrals to sources of competent, specialized care.
5. Discuss the importance for parents to foster a positive body image.

EAT-PA PARENTING

OUTCOME: The patient/family will understand methods of healthy parenting in dealing with children at risk for or diagnosed with an eating disorder.

STANDARDS:

1. Discuss the importance of developing a healthy, supportive relationship with their children, which includes:
 - a. spending quality time with children, which encourages them to approach parents with problems as needed
 - b. listening and communicating
 - c. monitoring for and addressing changes in behavior that may suggest emotional struggles, including alcohol, drug, and tobacco use, isolation, phobias, eating behavior, as well as sexual activity
 - d. showing interest in school activities
 - e. expressing affection and praise for good behavior
 - f. establishing realistic expectations, clear limits, and consequences
 - g. maintaining awareness of child's friends and their families
2. Discuss the adverse impact of overly controlling parenting behavior in the development of eating disorders. Discuss that the parent-child relationship will likely be better if the parent minimizes criticism, nagging, and negative messages.

EAT-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs

- e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
 3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
 4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
 5. Refer for medical and psychosocial support services for any risk factor identified.

EAT-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of eating disorders.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

EAT-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to eating disorders, and the risk of injury or suicide.

STANDARDS:

1. Discuss the dangers of unhealthy eating patterns on one's health, the potential dangers of injury due to restrictive diets, bingeing and purging, and excessive exercise.
2. Discuss/review the safety plan with the patient and family, including the no-harm contract and emergency procedures should the condition worsen, suicidal ideation arise, and/or urges to engage in risky/dangerous behavior arise.
3. Review the local resources and phone numbers, including the police, that may be utilized during a crisis, and may assist in transportation and safety compliance.

EAT-SCR SCREENING

OUTCOME: The patient/family will understand the proposed screening for people at risk of developing eating disorders.

STANDARDS:

1. Discuss the importance of early screening because it's so difficult to change body image attitudes and unhealthy eating patterns once they form.
2. Explain the process of screening by trained professionals.
3. Emphasize the importance of follow-up care.

EAT-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in coping with the stressors at the root of eating disorders.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in coping with unhealthy thoughts and lifestyle patterns.
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.

EAT-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

EAT-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options that may be used to treat eating disorders.

STANDARDS:

1. Explain that a combination of psychotherapy and medication interventions usually have better results than therapy or medication alone. The patient has a right to choose either option or both, and that the patient's active participation in the treatment decisions is critical to a good outcome.
2. Discuss the tailored treatment approach for the patient based on the patient's specific symptoms, issues, and strengths, as well as the severity of the disorder, which must address both the physical and psychological aspects of the problem, including:
 - a. individual, group, and family therapy

- b. nutritional counseling
 - c. support groups
 - d. residential treatment
3. Explain that psychotherapists have different styles and orientations for treating eating disorders, and that some styles may suit the patient better than others.
 4. Explain that psychotherapy often involves two phases of treatment, including breaking the binge-and-purge cycle by restoring normal eating patterns, and changing unhealthy thoughts and patterns.
 5. Explain that anti-depressant medication are often used in combination with psychotherapy to help reduce preoccupation with weight and body image, binge eating, and the depression and low self-worth which often accompanies eating disorders.
 6. Explain that the treatment plan will be made by the patient and treatment team after reviewing available options. Explain that treatment for eating disorders may vary according to the patient's life circumstances, severity of the condition, and available resources, which may include referrals to inpatient psychiatric hospitals or specialized Eating Disorder clinics.

ECZ - Eczema/Atopic Dermatitis

ECZ-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand the anatomy and physiology of skin structures affected by eczema/atopic dermatitis.

STANDARDS:

1. Review the anatomy/physiology and how it relates to the protective functions of the skin.
2. Discuss the presentation patterns of eczema/atopic dermatitis including papules, macules, vesicles, patches, plaques, dryness, itching, and scaling.
3. Discuss the impact of these skin changes on the patient's health or well being.

ECZ-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to eczema/atopic dermatitis.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with eczema/atopic dermatitis as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with eczema/atopic dermatitis, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to ["AOD - Alcohol and Other Drugs"](#).**
6. Refer to a mental health agency or provider.

ECZ-C COMPLICATIONS

OUTCOME: The patient/family will be able to recognize common and important complications and symptoms should be reported.

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. Explain how dryness and itching can cause breaks in the skin and allow bacteria to enter the body, causing infection. Pain, swelling, redness, drainage, or a fever should be reported immediately. **Refer to [“SWI - Skin and Wound Infections”](#).**
3. Emphasize that permanent scarring or hair loss may develop if not treated early.

ECZ-CM CASE MANAGEMENT

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

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”](#).**

ECZ-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

ECZ-DP DISEASE PROCESS

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

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. Discuss that atopic dermatitis or eczema can begin in infancy, can last for years, and can often be successfully controlled.
3. 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.
4. Discuss that seasonal flare-ups are common.

ECZ-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

ECZ-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding atopic dermatitis/eczema.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding atopic dermatitis/eczema and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

ECZ-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of eczema.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.

3. Refer to community resources, hospice, or support groups, as appropriate.

ECZ-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

ECZ-HY HYGIENE

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

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image. Discuss the importance of hand-washing and trimming fingernails in infection control.
3. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

4. 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.

ECZ-L LITERATURE

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

STANDARDS:

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

ECZ-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

ECZ-MNT MEDICAL NUTRITION THERAPY

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

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 dietitian 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. Consider the use of cotton blankets and clothing, rather than more irritating fabrics such as wool, or stiff synthetics like polyester.
3. Discuss ways of increasing skin moisture e.g., patting dry after bathing, applying moisturizing products immediately after bathing, using a room humidifier, and avoiding extreme temperatures.
4. Discuss the importance of avoiding products which contain alcohol, perfumes, harsh soaps, dyes or allergens and avoiding and avoiding skin contact with irritating chemicals, plants, jewelry, and other substances that trigger skin allergies and dermatitis.
5. Discuss strategies to avoid sunburn.

ECZ-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in eczema.
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.

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 reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.

5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

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 guiding medical care and decision making to best serve the patient's care preferences.

STANDARDS:

1. Explain that many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is unable to provide guidance at the time that decisions need to be made.
3. Explain that Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences for care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer,) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.
6. Refer to [“ADV - Advance Directives](#).

ELD-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, financial, 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.

ELD-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management to provide elders with the tools and resources to maintain their physical and behavioral health, reduce risk of developing chronic diseases, and to manage health to live as independently as possible.

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”](#).**

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. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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. Physical inactivity can lead to loss of strength, energy, and function. Older adults are at higher risk for the health problems that being active can prevent.

- Physical activity can be an important part of managing problems that might already be present, such as diabetes, hypertension, and hyperlipidemia.
- b. Maintenance of cognitive health is a vital part of healthy aging and quality of life. Cognition is a combination of mental processes that include the ability to learn new things, intuition, judgment, language, and remembering. Conditions that can cause cognitive impairment are Alzheimer's, other dementias, and conditions such as stroke and traumatic brain injury. Impairment can range from mild to severe. Some causes of cognitive impairment are related to treatable health issues (medication side effects, vitamin B12 deficiency, and depression).
 - c. Age-related conditions may interfere with the ability to engage in sexual activity.
 - i. Vaginal dryness from decreasing levels of estrogen, particularly after menopause may be improved from the use of lubricant and/or hormonal therapy as appropriate.
 - ii. Erectile dysfunction from reduced testosterone levels, decreased blood flow to the penis, impaired nerve function, or erectile tissue that has become less elastic over time. Health conditions, such as, heart disease, hypertension, diabetes and other disease processes may be factors. Possible interventions could include medications, mechanical devices (vacuum pump), or surgical implant.
 - iii. Low libido from chronic disease, depression or anxiety, reduced hormonal levels, or medication side effects. Consult with medical provider.
 - d. Changes in sleeping patterns may occur.
 - i. Health conditions, such as, obstructive sleep apnea, periodic involuntary limb movements, acid reflux, arthritis, chronic pain and other disease processes.
 - ii. Changes in daily schedule.
 - iii. Less physical activity.
 - iv. Day time sleeping leading to night time wakefulness.
 - v. Depression, stress, anxiety.
 - e. Vision impairment may occur from diseases associated with aging. Explain how a dilated eye exam can lead to early detection and potential treatment to improve or slow the progression of vision impairment from conditions, such as, macular degeneration, cataracts, diabetic retinopathy, and glaucoma. Nearsightedness, farsightedness, and astigmatism may be corrected with corrective eye wear, contacts, or surgery.
 - f. Hearing impairment can diminish the quality of life for older adults. Discuss routine hearing evaluations from an audiologist and wearing hearing aids, if

applicable. The etiology of age-related hearing loss is not known; some risk factors have been identified, such as, exposure to loud or persistent noises over long periods of time, tobacco smoking, and history of middle ear infections.

2. Explain that older individuals have several chronic diseases that need routine evaluation and management by a medical provider.
3. Depression may be difficult to diagnose because older adults may be living with one or more chronic health condition and receiving treatment with medications that potentially could alter mood and behavior leading to difficulty in recognizing depressive signs and symptoms. Family and caregivers should be instructed to watch for signs of depression. **Refer to [“DEP - Depressive Disorders](#).**

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 reduction of pain from arthritis and risk of fall and injury, 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. Emphasize the importance of follow-up care. Emphasize the importance of having appointments with the same healthcare provider when possible.
2. Discuss the procedure and process for obtaining follow-up appointments.
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. Discuss signs/symptoms that should prompt immediate follow-up.
6. Refer to community resources as appropriate, e.g., meals on wheels, elder transportation, vans, Medicare.

ELD-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high-risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
 - f. Keep regular healthcare visits and screening exams
 - g. Practice adequate hydration, nutrition, exercise, and stress management as components of wellness

4. Review the community resources available for help in achieving behavior changes.

ELD-HY HYGIENE**STANDARDS:**

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.

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 due to changes in functional status, e.g., nutrition, bathing, dressing, 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

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 dietitian for MNT as appropriate.

ELD-S SAFETY

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 prevent injuries, e.g., remove throw rugs, install bars in tub/shower, secure electrical cords, install ramps. Discuss fall prevention. **Refer to [“FALL - Fall](#).**
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](#).**
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.

ELEC - Electrolyte Imbalance

ELEC-C **COMPLICATIONS**

OUTCOME: The patient/family will understand the most common and important complications of this specific electrolyte abnormality.

STANDARDS:

1. Discuss common complications of this specific electrolyte abnormality.
2. Describe the signs/symptoms of common complications of this specific electrolyte abnormality.

ELEC-DP **DISEASE PROCESS**

OUTCOME: The patient/family will understand the process for this specific electrolyte disturbance.

STANDARDS:

1. Explain the specific electrolyte disturbance and the probable etiology.
2. Discuss the signs and symptoms of the specific electrolyte disturbance and usual progression if not treated.
3. Discuss the course of recovery if treated and the prognosis if not treated.

ELEC-EX **EXERCISE**

OUTCOME: The patient/family will understand the role of physical activity in as it relates to the specific electrolyte imbalance.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

ELEC-FU **FOLLOW-UP**

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of this specific electrolyte abnormality.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

ELEC-L LITERATURE

OUTCOME: The patient/family will receive literature about this specific electrolyte abnormality.

STANDARDS:

1. Provide the patient/family with literature regarding specific electrolyte abnormality.
2. Discuss the content of the literature.

ELEC-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for this specific electrolyte abnormality.

STANDARDS:

1. Discuss lifestyle adaptations specific to this specific electrolyte abnormality.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

ELEC-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

ELEC-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for this specific electrolyte abnormality.

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.

ELEC-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to this specific electrolyte abnormality.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.

5. Review nutrition as it relates to this specific electrolyte abnormality.
6. Refer to registered dietitian for MNT or other local resources as appropriate.

ELEC-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of developing this specific electrolyte abnormality.

STANDARDS:

1. Explain that prevention is generally easier and more effective than treatment.
2. Discuss the strategies to prevent the specific electrolyte disturbance.
3. Explain the importance of adherence to the recommended prevention plan and the notification of the provider if symptoms of the electrolyte disturbance occur.

ELEC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

ELEC-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

ENC - Encephalitis

ENC-ADV **ADVANCE DIRECTIVE**

OUTCOME: The patient/family 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 many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is able to provide guidance at the time that decisions need to be made.
3. Explain that the Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences of care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.

ENC-AP **ANATOMY AND PHYSIOLOGY**

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

STANDARDS:

1. Explain the normal anatomy and physiology of the brain and spinal cord and other associated structures of the central nervous system.
2. Discuss changes to anatomy and physiology as a result of encephalitis.
3. Discuss the impact of these changes on the patient's health or well-being.

ENC-BH **BEHAVIORAL AND EMOTIONAL HEALTH**

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to encephalitis.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with encephalitis as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with encephalitis, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. Refer to ["AOD - Alcohol and Other Drugs"](#).
6. Refer to a mental health agency or provider.

ENC-C COMPLICATIONS

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

STANDARDS:

1. Discuss common complications of encephalitis. Recovery following encephalitis is very varied. Many people come through the illness with little or no difficulties. The difficulties below are not reflective of every situation where encephalitis is involved. However because there are occasions where more severe problems can occur, the following complications with regard to the impact of encephalitis which are listed are as broad and far-reaching as possible:
 - a. seizures
 - b. personality changes
 - c. physical difficulties
 - d. memory problems
 - e. emotional problems
 - f. problems with pain or other sensations
 - g. problems with daily living skills
 - h. fatigue
 - i. hormone problems
 - j. cognitive (thinking) problems
 - k. problems with new learning
 - l. inability to understand and communicate
 - m. inappropriate behavior and poor social skills

n. Paralysis

Other complications may include:

o. Kidney failure

p. Adrenal gland failure

q. Shock

r. Death

2. Describe the signs/symptoms of common complications of encephalitis.

ENC-CM CASE MANAGEMENT

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

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”](#).**

ENC-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

ENC-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the encephalitis.

STANDARDS:

1. Discuss the disease process of encephalitis. Encephalitis may be broadly categorized as infectious, post-infectious, drug reactions, and autoimmune.
2. Explain that some causes of infectious encephalitis include:
 - a. Human herpesviruses (e.g., cold sores, glandular fever)
 - b. Human Immunodeficiency Virus (HIV)
 - c. Rash-causing viruses (e.g., mumps, measles, rubella)
 - d. Throat & chest viruses (e.g., influenza, enteroviruses)
 - e. Gut viruses (e.g., enteroviruses, Echo virus)
 - f. Insect-borne (e.g., LaCrosse Encephalitis virus, West Nile virus)
 - g. Bacteria (e.g., mycoplasma, meningococcal, pneumococcal and listeria)
 - h. Fungi (e.g., histoplasma, cryptococcus, candida)
 - i. Parasites (e.g. malaria, toxoplasma)

Other types include:

- j. Post-infectious Encephalitis
- k. Drug reactions
- l. Autoimmune Encephalitis

The above examples are not an exhaustive list.

3. Explain the disease process of encephalitis.
 - a. Encephalitis is characterized by seizures, stupor, coma, and related neurological signs. In more severe cases, neurological symptoms may include nausea and vomiting, confusion and disorientation, drowsiness, sensitivity to bright light, and poor appetite.
 - b. Patients with encephalitis often show mild flu-like symptoms. In more severe cases, patients may experience problems with speech or hearing, double vision, hallucinations, personality changes, loss of consciousness, loss of sensation in some parts of the body, muscle weakness, partial paralysis in the arms and legs, sudden severe dementia, impaired judgment, seizures, and memory loss.
 - c. Important signs of encephalitis to watch for in an infant include vomiting, body stiffness, constant crying that may become worse when the child is picked up, and a full or bulging fontanelle (the soft spot on the top of the head).

ENC-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

ENC-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in long-term recovery from encephalitis.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

ENC-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care. Patients who experience severe brain inflammation may need physical, speech, and occupational therapy once the acute illness is under control.
2. Discuss the procedure and process for obtaining follow-up appointments.

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. **Refer to [“ENC-C Complications”](#).**
5. Discuss the availability of community resources and support services and refer as appropriate.

ENC-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding encephalitis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding encephalitis and dealing with issues.
2. Provide the help line phone number or Internet address (URL), such as:
<http://www.cdc.gov/lac/>
<http://www.cdc.gov/ncidod/dvbid/westnile/index.htm>
http://www.ninds.nih.gov/disorders/encephalitis_meningitis/encephalitis_meningitis.htm

ENC-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of long-term recovery from encephalitis.

STANDARDS:

1. Explain the home management techniques.:
 - a. Very mild cases of encephalitis may be monitored at home by the physician and a caregiver. Supportive care includes fluids, bed rest, and over-the-counter analgesics to reduce fever and headache.
 - b. More severe cases may require hospitalization.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

ENC-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

ENC-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to encephalitis.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

ENC-L LITERATURE

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

STANDARDS:

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

ENC-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for encephalitis or post-encephalitis.

STANDARDS:

1. Discuss lifestyle adaptations specific to encephalitis or post-encephalitis.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

ENC-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

ENC-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for long-term recovery from encephalitis.

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.

ENC-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to long-term recovery from encephalitis.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

ENC-P PREVENTION

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

STANDARDS:

1. Discuss prevention of encephalitis. Encephalitis cannot be prevented except to try to prevent the illnesses that may lead to it. The best way to prevent infectious encephalitis is to take precautions to avoid exposure to viruses or bacteria that can cause the disease:
 - a. Wash hands frequently and thoroughly with soap and water, particularly after using the restroom and before and after meals.
 - b. Don't share tableware and beverages.
 - c. Teach children to practice good hygiene and to avoid sharing utensils at home and school.
 - d. Keep children's vaccinations current. Before traveling, ask healthcare provider about recommended vaccinations for different destinations.
2. Explain how to minimize exposure to mosquitoes and ticks by following these tips:
 - a. Wear long-sleeved shirts and long pants if outside between dusk and dawn when mosquitoes are most active and when in a wooded area with tall grasses and shrubs where ticks are more common.
 - b. Apply mosquito repellent. The Environmental Protection Agency (EPA) recommends two products-DEET and picaridin-to repel mosquitoes. Products with higher concentrations of the active ingredient provide longer protection. The EPA also recommends oil of lemon eucalyptus but cautions that its effect is comparable to low concentrations of DEET and provides protection for about an hour. Mosquito repellents can be applied to both the skin and clothes. To apply repellent to the face, spray it on the hands and then wipe it on the face. If using both sunscreen and a repellent, apply sunscreen first. The American Academy of Pediatrics advises parents not to use insect repellents on infants younger than 2 months of age. Instead, cover an infant carrier or stroller with mosquito netting. Tips for using mosquito repellent with children include the following:
 - i. Always assist children with the use of mosquito repellent.
 - ii. Spray on clothing and exposed skin.
 - iii. Apply the repellent when outdoors to lessen the risk of inhaling the repellent.
 - iv. Spray repellent on the hands and then apply it to the child's face. Take care around the eyes and ears.
 - v. Don't use repellent on the hands of young children who may put their hands in their mouths.
 - c. Avoid mosquitoes. Refrain from unnecessary activity in places where mosquitoes are most prevalent. If possible, avoid being outdoors from dusk till dawn, when mosquitoes are most active.

- d. Keep mosquitoes out of the home. Repair holes in screens on doors and windows.
- e. Get rid of water sources outside the home. Where possible, eliminate standing water in the yard, where mosquitoes can lay their eggs. Common problems include flowerpots or other gardening containers, flat roofs, old tires and clogged gutters.
 - i. Control mosquitoes in standing water. Fill ornamental pools with mosquito-eating fish. Use mosquito dunks — products that are toxic to mosquito larvae — in birdbaths, ponds and garden water barrels.
 - ii. Look for outdoor signs of viral disease. If you notice sick or dying birds or animals, report your observations to the local health department or public health agency.

ENC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

ENC-PRO PROCEDURE

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 of 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 for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification

- c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

ENC-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of complications resulting from encephalitis.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

ENC-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in complications of encephalitis.
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.

ENC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing (i.e., Neurological examination, laboratory testing of blood, urine, or bodily secretions, throat culture, lumbar puncture for cerebrospinal fluid collection and analysis, CT scan, MRI, or EEG.)
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. potential risk of refusal of recommended test(s): early diagnosis is vital, as symptoms can appear suddenly and escalate to brain damage, hearing and/or speech loss, blindness, or even death
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

ENC-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

ENC-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
 - a. Antiviral drugs may sometimes be used to treat certain types of viral encephalitis.
 - b. Anticonvulsants may be prescribed to stop or prevent seizures, along with sedatives to calm more severely infected persons and drugs to counter nausea and vomiting.
 - c. Corticosteroids and intravenous administration of carbohydrate solutions can reduce brain swelling.
 - d. Patients with breathing difficulties may require artificial respiration.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

ENCOP - Encopresis

ENCOP-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of bowel function and neurologic processes involved in bowel function.
2. Discuss the changes to anatomy and physiology as a result of encopresis.
3. Discuss the impact of these changes on the patient's health or well-being.

ENCOP-C COMPLICATIONS

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

STANDARDS:

1. Discuss that encopresis can result in soiling of stool and incontinence of urine.
2. Explain that people with encopresis often develop self esteem issues related to their inability to control body functions. The child with encopresis may feel ashamed and may wish to avoid situations (e.g. camp or school) that might lead to embarrassment.
3. When the incontinence is clearly deliberate, features of Oppositional Defiant Disorder or Conduct Disorder may be present. **Refer to [“ODD - Oppositional Defiant Disorder](#) and [“COND - Conduct Disorder](#).**

ENCOP-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family/caregiver will understand the impact and influences that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

ENCOP-DP DISEASE PROCESS/AGING

OUTCOME: The patient/family/caregiver will understand the disease process of encopresis.

STANDARDS:

1. Explain that the development of encopresis is a process which often involves:
 - a. Constipation resulting in or from hard stool that is painful to pass
 - b. Stool holding secondary to painful defecation or the child not wanting to take the time to go to the toilet
 - c. Long-standing dilation of the rectal vault (and the rectal muscles) up to 2-3 times the usual diameter
 - d. Disconnect of the defecation urge due to continuous stimulation of the neural pathway that signals the urge to defecate
 - e. Soiling of soft stool around the impacted stool in the rectal vault
 - f. Enuresis (in some cases) from the large bolus of stool in the rectum pushing on the bladder
2. Discuss that soiling of clothing and enuresis that happens with encopresis is out of the child's control and that the child is unaware of the soiling until the patient feels or smells the stool.
3. Discuss that after treatment of the encopresis it may take 6-12 months for the muscle and neural pathways to return to normal functioning and that relapses are common during this time period.
4. Discuss that in some cases, there may be an emotional, psychological, or behavioral component, including anxiety about defecating in a particular place, a general pattern of anxious or oppositional behavior, or a history of abuse or neglect.

ENCOP-EX EXERCISE

OUTCOME: The patient/family/caregiver will understand the essential role of physical activity in encopresis.

STANDARDS:

1. Discuss that intestinal motility will be decreased without adequate physical activity. Explain other benefits of physical activity, such as improvement in well being, stress reduction, sleep, and improved self image.
2. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal exercise plan.
3. Discuss the appropriate frequency, intensity, time, and type of activity

4. Refer to community resources as appropriate.

ENCOP-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

ENCOP-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding encopresis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding encopresis and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

ENCOP-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high-risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.

- c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

ENCOP-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 with alternative or additional sources for care and services (behavioral health services, traditional healing services, etc.).
2. Provide the patient/family with assistance in securing alternative or additional resources as needed

ENCOP-L LITERATURE

OUTCOME: The patient/family/caregiver will receive literature about encopresis

STANDARDS:

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

ENCOP-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

ENCOP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family/caregiver will understand the specific nutritional intervention(s) needed for encopresis.

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.

ENCOP-N NUTRITION

OUTCOME: The patient/family/caregiver will understand the role of nutrition in encopresis.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating. Explain that appropriate water intake is necessary to soften stools.
2. Discuss the need to incorporate fiber in the diet and the use of a fiber supplement as needed. Discuss methods for increasing fiber in the diet.
3. Explain some foods or beverages can exacerbate the condition, such as milk products and caffeinated and/or sugar beverages.
4. Refer to a registered dietitian for MNT as appropriate.

ENCOP-PA PARENTING

OUTCOME: The patient/family/caregiver will understand the parenting issues related to encopresis.

STANDARDS:

1. Explain that soiling and/or enuresis associated with encopresis is usually not a purposeful or controllable act.
2. Discuss that punishing or belittling is not constructive and may cause more problems and make encopresis more difficult to treat.
3. Explain that natural consequences, such as having the child clean the mess either alone or with assistance (depending on the child's ability) may be useful. The use of natural consequences is not and should not be used as punishment.
4. Discuss that most children with encopresis are not happy about their condition and should be handled with love and empathy when accidents happen. This is especially true during treatment and if the child is actively trying to help resolve the problem.

ENCOP-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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

ENCOP-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

ENCOP-TX TREATMENT

OUTCOME: The patient/family will understand the treatment plan and options for encopresis.

STANDARDS:

1. Explain that treatment of encopresis requires active participation from the family and patient for treatment to be successful.
2. Explain that treatment of encopresis is a slow process (months to greater than one year) during which relapses are common. Discuss the process for rapidly treating relapses
3. Discuss the process for clean-out.
4. Discuss the plan for stool softening:
 - a. Medication
 - b. Water
 - c. Dietary changes
5. Discuss the toilet retraining process.

6. Explain that in the case of psychological and behavioral causes to encopresis, the Behavioral Health treatment may include a combination of psychotherapy and medication interventions.
 - a. Explain that therapists have different styles and orientations for treating Encopresis, and some styles may suit the patient better.
 - b. Explain that medications may be prescribed intermittently or throughout the treatment process to address the underlying symptoms.

EOL - End of Life

EOL-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family/caregiver will understand the process of developing an advance directive and its role in guiding medical care and decision making to best serve the patient's care preferences.

STANDARDS:

1. Explain that many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is unable to provide guidance at the time that decisions need to be made.
3. Explain that Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences for care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer,) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.
6. Refer to ["ADV - Advance Directives"](#).

EOL-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components related to end of life conditions.

STANDARDS:

1. Discuss the common difficulty in coping with the end of life conditions that require a change in lifestyle ([refer to "EOL-LA Lifestyle Adaptations"](#)).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in the end of life conditions, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.

4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#).**
6. Refer to a mental health agency or provider, as necessary.

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 their perception of end of life.

STANDARDS:

1. Explain that “normal” grieving to anticipated loss may vary considerably among different cultural groups. **Refer to [“GRIEF - Grief/Bereavement”](#).**
2. Discuss the influence that their social, cultural, and spiritual traditions and variables have on the patient/family’s perception of end of life.
3. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
4. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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.
3. Discuss signs/symptoms of impending death, as appropriate.

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-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the end of life process.

STANDARDS:

1. Discuss the availability of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
3. Discuss signs/symptoms that should prompt immediate follow-up.
4. Discuss the availability of community resources, hospice, and support services and refer as appropriate.

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 end of life.
2. Explain that it is normal to grieve over end of life. **Refer to [“GRIEF - Grief/Bereavement”](#).**
3. 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, as appropriate.

EOL-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of end of life.

STANDARDS:

1. Explain the home management techniques.
2. Refer to community resources, hospice, or support groups, as appropriate.

EOL-L 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 the patient/family with literature on the patient's specific disease process, hospice care, end of life issues, advanced directives, support groups, or community resources.
2. Discuss the content of the literature.

EOL-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adjustments necessary to cope with the end of life

STANDARDS:

1. Discuss lifestyle adaptation specific to the end of life.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

EOL-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed 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. Constipation is common in opiate use and may require treatment.
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 patient/family concerns about addiction. Explain that addiction is not an issue for terminally ill patients.

EOL-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition at the end of life.

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. Other control measures should be discussed with the provider prior to initiation, as appropriate.
2. Encourage ingestion of small, frequent meals and/or snacks.
3. Emphasize the importance of mouth care as appropriate.
4. If a specific nutrition plan is prescribed discuss this with the patient/family.
5. Discuss that failure to thrive may be a sign of impending death and may be seen in spite of adequate nutritional intake.
6. Refer to a registered dietitian, as appropriate.

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 and may be multifaceted. **Refer to [“PM - Pain Management”](#).**
2. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain. For example:
 - a. Explain that regularly scheduled dosing of pain medication is more effective in the treatment of chronic pain than medications that are taken after the pain recurs.
 - b. Explain that acute, severe, or breakthrough pain should be immediately reported to the provider.
 - c. Discuss patient/family concerns about addiction. Explain that addiction is not an issue for terminally ill patients.
3. Explain non-pharmacologic measures that may be helpful with pain control.

EOL-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and processes of psychotherapy at the end of life.

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. Emphasize the importance of openness and honesty with the therapist.
4. Discuss issues of safety, confidentiality, and responsibility.
5. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

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 unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in the end of life.
3. Emphasize the importance of seeking professional help as needed to reduce stress.

EOL-TX TREATMENT

OUTCOME: The patient/family will understand the treatment plan at the end of life.

STANDARDS:

1. 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 psychotherapy may be beneficial for end of life process. Explain that individual psychotherapy or family therapy are options to facilitate the grieving process (**refer to ["GRIEF-TX Treatment"](#)**).
5. Discuss how to integrate the social, cultural, or spiritual traditions of the patient and family into the treatment process, based on the assessment of their needs and perceptions about the end of life.

ENU - Enuresis (Bedwetting)

ENU-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

ENU-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to enuresis.

STANDARDS:

1. Discuss that bedwetting can be embarrassing and guilt producing to children and can be very stressful for families.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common for the patient and family, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Refer to a mental health agency or provider.

ENU-C COMPLICATIONS

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

STANDARDS:

1. Explain that other behavioral or emotional symptoms and disorders may occur in children with Enuresis, especially if left untreated.
2. Explain that the amount of impairment associated with enuresis is a function of the limitation on the child's social activities (e.g. ineligibility for sleep away camps), or its effect on the child's self-esteem, the degree of social ostracism by peers, and the anger, punishment, and rejection on the part of the caregivers.

ENU-CM CASE MANAGEMENT

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

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”](#).**

ENU-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

ENU-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of enuresis.

STANDARDS:

1. Explain enuresis is the repeated voiding of urine into the bed or clothes (whether voluntary or intentional) at least twice a week for at least three consecutive months.
2. Explain that enuresis can be caused by medical problems, psychological problems, or other factors.
3. Discuss the onset of enuresis.
4. Explain that bedwetting is often a source of embarrassment, shame, and social ostracism.

5. Explain that bedwetting may resolve without treatment. However, bedwetting after the age of seven can be indicative of more serious problems, e.g., diabetes, kidney disease.

ENU-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Moisture alarms are designed to alert the patient before wetting the bed. To be effective, the child must awake as soon as the alarm goes off, go to the bathroom, and change the bedding.
 - b. Benefits of using the equipment.
 - c. Types and features of the equipment.
 - d. Proper function of the equipment.
 - e. Signs of equipment malfunction and proper action in case of malfunction.
 - f. Infection control principles, including proper disposal of associated medical supplies.
 - g. The importance of not tampering with any medical device.
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

ENU-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

ENU-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

ENU-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding enuresis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding enuresis and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

ENU-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Review the community resources available for help in achieving behavior changes.

ENU-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to enuresis.

STANDARDS:

1. Discuss the additional hygienic practices needed for children who are bedwetting.
2. Discuss the importance of hand-washing in infection control, especially in relationship to food preparation/consumption, child care, and toilet use.
3. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.

ENU-L LITERATURE

OUTCOME: The patient/family will receive literature about enuresis (bedwetting).

STANDARDS:

1. Provide the patient/family with literature on enuresis or bedwetting.
2. Discuss the content of the literature.

ENU-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for enuresis.

STANDARDS:

1. Discuss lifestyle adaptations that will be necessary until the child develops continence.
2. Discuss that family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

ENU-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.

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.

ENU-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for enuresis.

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.

ENU-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to enuresis.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Review enuresis (bedwetting).
6. Refer to registered dietitian for MNT or other local resources as appropriate.

ENU-PA PARENTING

OUTCOME: The patient/family will understand parenting skills necessary to help the child regarding enuresis.

STANDARDS:

1. Explain the importance for parents to cultivate patience with the child and to avoid directly expressing anger, frustration, or hostility about the bedwetting to the child.
2. Explain that punishment for bedwetting at night can emotionally hurt the child and should not be practiced.
3. Discuss methods for appropriate parenting at home, which may include:
 - a. Not allowing siblings to “tease” the child
 - b. By having a small reward for dry nights
4. Discuss the importance of providing emotional support and unconditional assistance to the child.
5. Refer the family to mental health services/family counseling if the family is becoming overwhelmed.

ENU-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of enuresis.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

ENU-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in coping with enuresis.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.

2. Explain the role of effective stress management in enuresis.
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
4. Provide referrals as appropriate.

ENU-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

ENU-TX TREATMENT

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

STANDARDS:

1. Explain that the treatment plan will be made by the family and treatment team after reviewing available options. Emphasize the importance of active participation by the patient/family in the development of and participation with treatment plan.
2. Explain that the behavioral therapy is the first approach to the treatment of Enuresis, which includes:
 - a. Having the child urinate just before going to bed, and reminding the child to get up at night, as needed.
 - b. Having the child “rehearse” waking up to go to the bathroom.
 - c. Stop using diapers at night, and place a plastic cover over the mattress to protect it.
 - d. If an accident occurs, have the child change into new pajamas and place dry towels over the wet spot.
3. Explain that other approaches can be added with a professional’s advice:
 - a. Bladder training may help the child to increase bladder capacity.
 - b. Night wet alarms can remind the child to wake up when urine is passed in the bed.
4. Explain that medication intervention may be prescribed in combination with therapy.

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 the ocular condition, failure to manage this condition, or from treatment.

STANDARDS:

1. Discuss the common or significant complications associated with the ocular 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.

EYE-DP DISEASE PROCESS

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

STANDARDS:

1. Discuss the current information regarding causative factors and pathophysiology of the ocular condition.
2. Discuss the signs/symptoms and usual progression of the ocular condition.
3. Discuss the signs/symptoms of exacerbation/worsening of the ocular 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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 the 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 the specific eye conditions.

STANDARDS:

1. Provide the patient/family literature on the specific eye conditions.
2. Discuss the content of the literature.

EYE-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand 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: nutrition, physical activity, 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

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. Discuss lifestyle habits that increase the risk for the onset or progression of the specific eye condition.
2. Discuss behaviors that reduce the risk for the onset or progression of a specific eye condition, e.g., proper nutrition, safety, and infection control practices.

EYE-PM PAIN MANAGEMENT

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

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"](#).

3. Explain that short term use of narcotics may be helpful in pain management as appropriate.
4. Discuss non-pharmacologic measures that may be helpful with pain control, e.g., warm or cool packs.

EYE-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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

EYE-S SAFETY

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

STANDARDS:

1. Explain the injuries can cause certain ocular conditions.
2. Discuss injury prevention adaptations such as safety glasses or goggles.

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, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

EYE-TLH TELE-HEALTH

OUTCOME: The patient/family will have a basic understanding of teleophthalmolog.

STANDARDS:

1. Explain that images of the eye are captured and transmitted to the qualified ophthalmologists for interpretation.
2. Explain the purpose of the assessment is for eye conditions and that there is no preparation required.

EYE-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 risks, side effects, and expected benefits. Explain the risks/benefits of treatment and non-treatment.

F**FACT - Factitious Disorder**

(formally called Münchausen Syndrome)

FACT-C COMPLICATIONS

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

STANDARDS:

1. Discuss that individuals with factitious disorders often seek numerous medical evaluations, diagnostic procedures, surgeries, and hospitalizations, in addition to concurrent treatments with multiple physicians, which often leads to increased risk of morbidity and hazardous combinations of treatment.
2. Discuss that factitious disorder is usually incompatible with the individual's maintaining steady employment, family ties, and interpersonal relationships.
3. Explain that individuals with factitious disorder are at risk for drug addiction as a result of surreptitious use of psychoactive substances for purpose of producing symptoms that suggest a mental or medical diagnosis (**refer to [“AOD - Alcohol and Other Drugs”](#)**).
4. Explain that individuals with factitious disorders may choose to hurt themselves as part of the nature of their illness, and may even attempt or complete suicide (**refer to [“SI - Suicidal Ideation and Gestures”](#)**).

FACT-CM CASE MANAGEMENT

OUTCOME: The patient/family will understand the importance of integrated case management in the conditions associated with factitious disorder.

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. Discuss the importance of open communication with all providers, and not to seek the same treatment from multiple sources.
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”](#)**.

FACT-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

FACT-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the signs and symptoms of factitious disorder (formerly called Münchausen Syndrome).

STANDARDS:

1. Discuss the signs and symptoms of factitious disorder involving:
 - a. The intentional production or feigning of physical or psychological signs or symptoms for the purpose of assuming a sick role.
 - b. External incentives or motivations for the behaviors are absent, e.g., economic gain, avoiding legal responsibilities, or physical well being, as in Malingering.
2. Explain that Münchausen by proxy syndrome is relatively uncommon condition that involves the exaggeration or fabrication of illnesses or symptoms by a primary caregiver. **Refer to [“ABNG - Abuse and Neglect \(child or elder\)”](#).**
3. Explain that the internal motivations are presumed to be an unconscious cry for help. Reframe the patient’s problems as psychiatric in nature.
4. Explain that rarely the course of this disorder is limited to one or more brief episodes, but usually it is chronic, and may include a life-long pattern of successive hospitalizations and surgeries. It usually appears to remit within the fourth decade of life.
5. Explain that the pathophysiology of factitious disorder is unclear, although abnormalities have been reported in MRI and SPECT of the brains of those with factitious disorder, as well as in psychological testing.

FACT-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

FACT-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

FACT-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.

FACT-L LITERATURE

OUTCOME: The patient/family will receive literature about factitious disorder.

STANDARDS:

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

FACT-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for improving overall well-being.

STANDARDS:

1. Discuss lifestyle adaptations specific to reducing stress and improving relationships and social support networks, including regular exercise and healthy diet.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

FACT-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

FACT-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to factitious disorder.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

FACT-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of factitious disorder.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

FACT-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to factitious disorder and the risk of suicide or other risky behavior.

STANDARDS:

1. Discuss the adverse health consequences for multiple medical procedures.
2. Discuss/review the safety plan with the patient and family, including the no-harm contract and emergency procedures should the condition worsen, suicidal or homicidal ideation arise, and/or urges to engage in risky/dangerous behavior arise.

3. Review the local resources and phone numbers, including the police that may be utilized during a crisis, and may assist in transportation and safety compliance.

FACT-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in developing internal coping skills.
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.

FACT-TX TREATMENT

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

STANDARDS:

1. Explain that a combination of psychotherapy and medication interventions usually has better results than therapy or medication alone. The patient has a right to choose either option or both, and that the patient's active participation in the treatment decisions is critical to a good outcome.

2. Explain that therapists have different styles and orientations for treating factitious disorder, and that some styles may suit the patient better than others.
3. Explain that medication intervention is often used in combination with psychotherapy to help alleviate any associated symptoms or co-morbid conditions.
4. Explain that the treatment plan will be made by the patient and treatment team after reviewing available options. Explain that treatment for factitious disorder may vary according to the patient's life circumstances, severity of the condition, the patient's participation in the choices, and available resources.

FTT - Failure to Thrive (All Ages)

FTT-ALL ALLERGIES

OUTCOME: The patient/family will understand food allergies and their influence on the failure to thrive.

STANDARDS

1. Explain that protein allergies may increase the risk of failure to thrive, e.g., cow's milk protein, soy milk protein.
2. Discuss the impact that the specific food allergy may have on the infant and its inability to successfully obtain the nutrients that the infant needs.
3. Discuss that unrecognized food allergies may lead to refusal of food, vomiting, and other symptoms.

FTT-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological aspects of coping with the effects of the failure to thrive.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of the failure to thrive on the parent (**refer to [“FTT-LA Lifestyle Adaptations”](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in coping with failure to thrive.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs as a consequence of this diagnosis. **Refer to [“AOD - Alcohol and Other Drugs”](#)**.
6. Refer to a mental health agency or provider.

FTT-C COMPLICATIONS

OUTCOME: The patient/family will understand that the complications failure to thrive (FTT).

STANDARDS

1. Discuss that complications seen in children may include small head circumference, muscular wasting, apathy, weight loss, anemia, poor weight gain and learning failures (e.g., slow to talk and behavior problems).
2. Explain that loss of appetite is common and may lead to other eating disorders or anorexia in both children and adults. Young infants may fail to cry or request food after prolonged starvation.
3. Discuss the effects of malnourished state on growth and development in early age and this may result in permanent physical, cognitive, and emotional changes.
4. Explain that complications in adulthood may include debility, cardiac cachexia or chronic obstructive pulmonary disease, chronic pancreatic deficiency, infections, and hyperphagia or hypophagia.
5. Explain that failure to thrive in children is a common symptom of celiac disease.

FTT-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

FTT-DP DISEASE PROCESS

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

STANDARDS:

1. Explain that FTT in children can occur from social factors including inadequate feeding procedures or inadequate caretaker behaviors or neglect. Explain that FTT can result from psychological factors that influence an infant's feeding behavior.
2. Explain that FTT in children can result from disease states, such as metabolic or endocrine disorders, allergies, chronic infections/immunodeficiency, Cystic Fibrosis, Cleft Palate, and Crohn's disease, cancer, or physical or mental disabilities.

3. Explain that premature or low birth weight infants have delayed neuromuscular development, small gastric capacity, and higher metabolic needs that predispose them to FTT.
4. Explain that FTT in the elderly results from insufficient intake of protein and calories.
5. Explain that FTT in the elderly can be caused by disease, substance abuse, neglect, sensory deficits, confusion, dementia, delirium, dysphasia, depression, destitution, and despair.

FTT-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

FTT-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

FTT-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high-risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

FTT-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to FTT.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.

3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

FTT-L LITERATURE

OUTCOME: The patient/family will receive literature about correcting FTT.

STANDARDS:

1. Provide the patient/family with literature or a written treatment care plan.
2. Discuss the content of the literature.

FTT-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for a FTT individual.

STANDARDS:

1. Discuss lifestyle adaptations specific to feeding treatment plan.
2. Discuss that family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

FTT-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.

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.

FTT-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for FTT.

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
 - a. identification of the patient's nutritional problem
 - a. identification of a specific nutrition intervention therapy plan
 - a. evaluation of the patient's nutritional care outcomes
 - a. 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.

FTT-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to FTT.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of keeping and maintaining a calorie count and documenting eating behaviors.
4. Explain that nutrition support such as enteral or parenteral feeding may be necessary to correct FTT.
5. Explain that adequate hydration is necessary and best after meals; use of high-calorie, oral supplements is beneficial.
6. Refer to registered dietitian for MNT.

FTT-P PREVENTION

OUTCOME: The patient/family will understand how FTT can be prevented.

STANDARDS:

1. Discuss that early interventions by trained home visitors can promote a more nurturing environment and reduce developmental delays in primary FTT.
2. Discuss options to help reduce side effects of disease that can precipitate FTT.
3. Refer to appropriate healthcare providers if psychological or behavioral issues are suspected or identified that compromise the care of the individual.

FTT-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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

FTT-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in FTT.

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.

FTT-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

FTT-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 participation with treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

FALL - Fall

FALL-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of the area affected by the fall.
2. Discuss changes to anatomy and physiology as a result of the fall.
3. Discuss the impact of these changes on the patient's health or well-being. Many human physical risk factors have been identified for falls and falls injuries in older people. Factors contributing to falls can be considered as:
 - a. Intrinsic (or host), which includes age-related changes in the balance systems as well as pathology in any component of the balance system. Medications and their side effects (such as dizziness) can also be considered under the umbrella of intrinsic falls risk factors.
 - b. Extrinsic (or environmental/situational), which includes objects or circumstances contributing to falls risk, such as uneven pavement, slippery surfaces, and poor lighting.

FALL-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components associated with a fall.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being injured in a fall that requires a change in lifestyle (**refer to ["FALL-LA Lifestyle Adaptations"](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common with a fall, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about problems associated with a fall, and the importance of seeking help in accepting and coping with the fall.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to ["AOD - Alcohol and Other Drugs"](#)**.
6. Refer to a mental health agency or provider.

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.
3. Explain that as a person gets older, your bones slowly lose minerals and become less dense. Gradual loss of density weakens bones and makes them more susceptible to a hip fracture. A fracture can be a serious injury, particularly if you're older, and complications can be life-threatening requiring surgery to repair a fracture and recover requires time and patience.
4. Explain that some falls result in fractures that may require surgery. After surgery, there is a chance of developing a blood clot. It is possible for a blood clot to become lodged in a pulmonary artery, blocking blood flow to lung tissue. This condition, called pulmonary embolism, can be fatal. Risks of traction and being immobile might include:
 - a. Blood clots
 - b. Bedsores
 - c. Urinary tract infection
 - d. Pneumonia
 - e. Muscle wasting
5. Additionally, people who have had one fracture have a significantly increased risk of having another one.

FALL-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.

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 unintentional injury from any source is the most common cause of death in older people of which falls is the most common cause. Explain that there are many health-related factors that can increase the chance for falls. These include:
 - a. Explain that some medications, such as tranquilizers, sedatives, pain medications, antihypertensives, or diuretics may cause dizziness and disorientation.
 - b. Explain that illness, therapeutic procedures, and diagnostic tests may leave the patient weak and unsteady.
 - c. 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.
2. Explain that the hospital may seem unfamiliar, especially when awakened at night, and this, combined with other factors, may result in disorientation.
3. Discuss that infants and small children may be at increased risk of injury from falls, as appropriate.

FALL-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate (when appropriate) the proper use and care of equipment provided to facilitate movement associated with the fall.

STANDARDS:

1. Explain that specific equipment may be required for patients who have suffered from a fall. Discuss the specific equipment the patient may need to use such as canes, crutches, wheelchairs, and other equipment.
2. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies

- g. The importance of not tampering with any medical device
3. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration 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.

FALL-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image. Explain that exercises and physical activity can improve your balance and help to prevent falls. While holding the back of a chair, sink, or counter:
 - a. Stand on one leg at a time for a minute and then slowly increase the time.
 - b. Try to retain balance with the eyes closed or without holding on.
 - c. Stand on toes for a count of 10, and then rock back on the heels for a count of 10.
 - d. Make a big circle to the left with the hips, and then to the right. Do not move the shoulders or feet. Repeat five times
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

FALL-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

FALL-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of injuries from a fall.

STANDARDS:

1. Discuss with the patient how to improve home safety.
 - a. Keep all rooms free from clutter, especially the floors.
 - b. Keep floor surfaces smooth but not slippery. When entering rooms, be aware of differences in floor levels and thresholds.
 - c. Check that all carpets and area rugs have skid-proof backing or are tacked to the floor, including carpeting on stairs.
 - d. Keep electrical and telephone cords and wires out of walkways.
 - e. Be sure that all stairwells are adequately lit and that stairs have handrails on both sides. Consider placing fluorescent tape on the edges of the top and bottom steps.
 - f. Install grab bars on bathroom walls beside tubs, showers, and toilets. If unstable on feet, consider using a plastic chair with a back and nonskid leg tips in the shower. Use a rubber bath mat in the shower or tub.
 - g. Use bright light bulbs in the home. Consider adding ceiling fixtures to rooms lit by lamps only, or install lamps that can be turned on by a switch near the entry point into the room. Another option is to install voice- or sound-activated lamps.
 - h. Consider purchasing a portable phone that can be taken from room to room. It provides security to answer the phone without rushing for it and to call for help should an accident occur.
 - i. Refer to community resources or support groups that can provide assistance, such as home health, CHR, and senior citizen programs that may provide services in bad weather.
2. Discuss that addition to home modifications, some older adults may need to use personal assistive safety and mobility devices. An occupational or physical therapist can provide the training needed to use these devices properly.

FALL-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices. Falls can result in fractures to long term hospitalization and might include a loss of self-esteem and confidence. Because the consequences of falls are numerous and significant, falls and their resulting injuries are important health issues that cannot be overlooked.
 - a. Physical consequences of a fall:
 - i. Fractures, especially of hip or forearm
 - ii. Pain or discomfort
 - iii. Health problems due to prolonged immobility
 - iv. Difficulty or inability to move around independently, especially for long periods of time
 - v. Unsteady walking pattern
 - b. Social consequences of a fall:
 - i. Loss of independence
 - ii. Changes to daily routine
 - iii. Financial costs of hospitalization
 - iv. Loss of social contacts due to long-term hospitalization
 - v. Decreased quality of life
 - c. Psychological consequences of a fall
 - i. Frustration at losing independence to carry out daily activities
 - ii. Fear of falling again
 - iii. Distress resulting from uncertainty and anxiety in life after suffering from fall-related injury
 - iv. Embarrassment from injury and/or use of walking aids
 - v. Loss of self-esteem due to inability to take care of oneself after falling
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge

- e. get help when necessary
- 4. Review the community resources available for help in achieving behavior changes.

FALL-L LITERATURE

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

STANDARDS:

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

FALL-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for a fall.

STANDARDS:

1. Discuss lifestyle adaptations specific to preventing falls. Explain that a patient should examine the many risk factors and target those risks that the patient can impact:
 - a. Home assessment and modifications to reduce environmental hazards within the home.
 - b. Adequate exercise or physical activity; muscle strengthening and balancing activities will help to reduce risks of falling.
 - c. Medication reviews.
 - d. Vision assessment and modification.
 - e. Feet and footwear review.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

FALL-P PREVENTION

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

STANDARDS:

1. Discuss that falling can put one at risk for serious injury:
 - a. Loss of footing or traction that can cause tripping or slipping
 - b. Slow reflexes, which makes it hard to maintain balance or move out of the way of a hazard

- c. Balance problems
 - d. Reduced muscle strength
 - e. Poor vision
 - f. Illness
 - g. Taking medicines
 - h. Drinking alcohol
2. Explain that illnesses and some medicines can promote dizziness, confusion, or slowness. Medication that may increase the risk of falls are:
 - a. Blood pressure pills
 - b. Heart medicines
 - c. Diuretics (water pills)
 - d. Muscle relaxants
 - e. Sleeping pills
 3. Discuss that drinking alcohol can lead to a fall because it can:
 - a. Slow the reflexes
 - b. Cause dizziness or sleepiness
 - c. Alter one's balance
 - d. Cause risk taking that can lead to falls
 4. Discuss that at any age, people can make changes to lower the risk of falling. Some tips to help prevent falls are:
 - a. Keep rooms free of clutter, especially on floors
 - b. Use plastic or carpet runners
 - c. Wear low-heeled shoes
 - d. Do not walk in socks, stockings, or slippers
 - e. Be sure rugs have skid-proof backs or are tacked to the floor
 - f. Be sure stairs are well lit and have rails on both sides
 - g. Put grab bars on bathroom walls near tub, shower, and toilet
 - h. Use a nonskid bath mat in the shower or tub
 - i. Keep a flashlight next to the bed
 - j. Use a sturdy stepstool with a handrail and wide steps
 - k. Add more lights in rooms
 - l. Buy a cordless phone to avoid rushing to the phone when it rings and to provide a means of calling for help (when the fall happens)

5. Explain some ways to protect one's bones are:
 - a. Get enough calcium and vitamin D each day.
 - b. Walk, climb stairs, lift weights, or dance each day.
 - c. Talk with the doctor about having a bone mineral density (BMD) test.
 - d. Talk with the doctor about taking medicine to make the bones stronger.

FALL-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

FALL-S SAFETY

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

STANDARDS:

1. Explain that there are precautionary measures that may prevent accidental falls. Some ideas include:
 - a. Explain that wearing non-skid slippers when out of bed may prevent slipping and falling.
 - b. 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.
 - c. Discuss that throw rugs, wires across the floor, objects on the floor, unlevelled 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.
2. Emphasize the importance of knowing how to request assistance.

- a. 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.
 - b. 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.
 - c. 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.
3. 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.

FALL-SCR SCREENING

Everyone over the age of 65 should be asked once a year if a fall has taken place. If the fall has taken place but the patient essentially has a normal gait and balance, no further intervention is required. The patient will need a complete fall evaluation in any of the following situations: (a) if the fall has taken place but there is an abnormal gait and balance on a simple office test, (b) if there has been several falls, or (c) if a fall has been sustained.

OUTCOME: The patient/family will understand 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.
 - a. Assessment: All older persons (65 years and older) should be asked at least once a year about falls.
 - b. All older persons who report a single fall should be observed as they stand up from a chair without using their arms, walk several paces, and return (i.e., the "Get Up and Go Test").
 - c. Persons who have difficulty or demonstrate unsteadiness performing this test should have a fall evaluation.
 - d. Older persons who present for medical attention because of a fall, or report recurrent falls in the past year, should have a fall evaluation. A fall evaluation is defined as an assessment that includes the following:
 - i. A history of fall circumstances, acute and chronic medical problems, and mobility levels (including the role of alcohol, if any, in the fall).
 - ii. An examination of vision.
 - iii. An examination of gait and balance and lower extremity joint function.

- e. An examination of basic neurologic function, including mental status, muscle strength, lower extremity peripheral nerves, proprioception, reflexes, tests of cortical, extrapyramidal, and cerebellar function.
 - f. Assessment of basic cardiovascular status including heart rate and rhythm, postural pulse and blood pressure and, if appropriate, heart rate and blood pressure responses to carotid sinus stimulation.
 - g. Interventions:
 - i. Gait training and advice on the appropriate use of assistive devices.
 - ii. Review and modification of medications (medication review by pharmacy).
 - iii. Exercise program with balance training as one of the components.
 - iv. Home evaluation and modification of environmental hazards.
 - v. Treatment of postural hypotension if present.
 - vi. Treatment of cardiovascular disorders, including cardiac arrhythmias if present.
 - vii. Referral for substance abuse evaluation and treatment if indicated.
 - h. Additional interventions for consideration, to reduce risk of injury after fall:
 - i. Offer Calcium/Vitamin D and MVI if not already taking.
 - ii. Evaluate risk for osteoporosis and treat accordingly.
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.

FALL-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

FALL-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

FP - Family Planning

FP-ABST ABSTINENCE

OUTCOME: The patient will understand the role of abstinence in family planning.

STANDARDS:

1. Explain that abstinence is the only 100% effective method to prevent pregnancy and sexually transmitted infections.
2. Explain that even a single sexual encounter could result in pregnancy and sexually transmitted infections.

FP-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient will have a basic understanding of anatomy and physiology as it relates to male and female reproductive system.

STANDARDS:

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

FP-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

FP-DPH DIAPHRAGM

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

STANDARDS:

1. Discuss the use of a diaphragm as a barrier method of contraception. When used correctly and consistently every time, it is very effective. Discuss failure rates.

2. Explain how to insert a diaphragm and leave it in place for at least 6 hours. Emphasize the use of Spermicide can increase the transmission of HIV infection.
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 reduce the chance of pregnancy, if used consistently and correctly every time, but does not reduce the risk of sexually transmitted infections.
5. Discuss the proper cleaning and care of the diaphragm.

FP-DPO DEPOT MEDROXYPROGESTERONE INJECTIONS

OUTCOME: The patient/family will understand risks, benefits, side effects, and effectiveness of depot medroxyprogesterone injections (shots).

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, weight gain, and menstrual cycle disturbances. Increase the intake of vitamin D and calcium (**refer to [“FP-M Medications”](#) and [“FP-N Nutrition”](#)**).
3. Explain the need for follow up if pregnancy is suspected.
4. Explain that depot medroxyprogesterone can reduce the chance of pregnancy, if used correctly, but does not reduce the risk of sexually transmitted infections.
5. Discuss that long term use can make it difficult to get pregnant from 9-12 months after discontinuation. This may not be a good contraceptive method for those who want to have family in the near future.

FP-EC EMERGENCY CONTRACEPTION (POST-COITAL)

OUTCOME: The patient/family will understand risks, benefits side effects, safety, and effectiveness of Emergency Contraception. Emergency Contraception should not be used as a routine contraceptive method.

STANDARDS:

1. Explain there are several methods of emergency contraception. Discuss each method of action and effectiveness of Emergency Contraception.
2. Explain indications for use. Emergency Contraception is used to help prevent pregnancy after unprotected sexual intercourse or contraceptive failure. Emergency contraception must be given within 3 days after unprotected sex.

3. Discuss the contraindications of Emergency Contraception.
4. Review side effects and their management:
 - a. Side effects include breast tenderness, nausea, and vomiting which are usually limited to the first three days after treatment. Nausea and vomiting can be minimized by the use of anti-emetic pre-treatment.
 - b. A small number of women may experience irregular bleeding or spotting after taking Emergency Contraception; this is not their menses. Most women will have their menstrual period within one week before or after the expected time.
 - c. Discuss that pregnancy needs to be ruled out before giving emergency contraception and if there is a history of blood clots the patient may need to given a progestin only Emergency Contraception.
 - d. Discuss the failure rates of different emergency contraception methods.

FP-FC FOAM AND/OR CONDOMS

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

STANDARDS:

1. Discuss or demonstrate the proper use and application of foam and/or condoms.
 - a. Emphasize the importance of using a new condom or foam each time intercourse takes place.
 - b. Explain that condoms must be applied before penetration.
 - c. Emphasize that the male must withdraw before erection subsides.
2. Discuss the risks and benefits of concurrent use of spermicidal foam and failure rate of concurrent use.
3. Discuss the use of spermicidal suppositories and intravaginal films.
4. Discuss that condoms provide protection against most Sexually Transmitted Infections when used consistently and correctly every time. Discuss failure rates.
5. Discuss the proper storage and disposal of condoms and/or foam.

FP-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.

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.

FP-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding family planning methods.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding family planning methods and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

FP-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high-risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

FP-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to family planning.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

FP-IC IMPLANT CONTRACEPTION

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

STANDARDS:

1. Provide the patient/partner with alternative or additional sources for care and services.
2. Provide the patient/partner 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 intrauterine devices (IUDs).

STANDARDS:

1. Explain how IUDs work and that IUDs are more easily retained in women who have had babies.
2. Emphasize the importance of monthly string checks and periodic replacements of IUDs.
3. Emphasize the importance of reporting abnormal vaginal discharge, fever, or pain with intercourse.
4. Discuss contraindications to placement of IUDs (they might be contraindicated in women who have had no children or have more than one sexual partner).
5. Explain that the IUD can prevent pregnancy, if used correctly, but does not reduce the risk of sexually transmitted infections. Explain that STIs may be more serious in women who have IUDs. Discuss failure rates of IUDs.

FP-L LITERATURE

OUTCOME: The patient/partner will receive literature about family planning.

STANDARDS:

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

FP-M MEDICATIONS

OUTCOME: The patient/partner will understand the purpose, proper use, and expected outcomes of the 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. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.

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.

FP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/partner 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/partner will receive information regarding types of birth control, including the advantages, disadvantages, and effectiveness.

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/partner will understand the role of proper nutrition before pregnancy.

STANDARDS:

1. Discuss the importance of healthy nutrition. Refer to a registered dietitian for MNT as appropriate.

2. Explain the importance of folic acid. Identify food sources 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.
3. Refer to ["PN-N Nutrition"](#) for information on other nutritional needs.

FP-OC ORAL CONTRACEPTIVES

OUTCOME: The patient/partner 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, failure rates, and signs/symptoms of complications.
5. Explain that oral contraceptives can prevent pregnancy if used consistently and 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-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations

- h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
 2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
 3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
 4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
 5. Refer for medical and psychosocial support services for any risk factor identified.

FP-ST STERILIZATION

OUTCOME: The patient/partner will understand permanent contraceptive methods (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. They do not reduce the risk of sexually transmitted infections.
2. Review the 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 Indian Health Service (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.

FP-TD TRANSDERMAL (PATCH)

OUTCOME: The patient/partner will understand the safe and effective use of trans-dermal contraception.

STANDARDS:

1. Discuss the actions, benefits, and common side effects of trans-dermal 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, failure rate, 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 trans-dermal contraception can prevent pregnancy, if used consistently and correctly, but does not reduce the risk of sexually transmitted infections.

FP-TE TESTS

OUTCOME: The patient/partner 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 (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

FEED - Feeding Disorders of Infancy or Early Childhood

FEED-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components as it relates to feeding disorders.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with a feeding disorder, which is potentially a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with a feeding disorder, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).**
6. Refer to a mental health agency or provider.

FEED-C COMPLICATIONS

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

STANDARDS:

1. Explain that Pica and other feeding disorders often come to clinical attention only when the individual presents with medical complications although it can be prevented with good support and parental interaction with the child.
2. Discuss the complications of Pica, including lead poisoning as a result of ingesting paint or paint-soaked plaster, mechanical bowel problems, intestinal obstruction as a result of hair balls, intestinal perforation, or infections, such as toxoplasmosis or toxocariasis as a result of ingesting feces or dirt.
3. Discuss that the complications for Rumination Disorder may include malnutrition, because regurgitation immediately follows the feeding. Weight loss, failure to meet expected weight gains, and death can result (**refer to [“FTT - Failure to Thrive \(All Ages\)](#)**).
4. Explain that under-stimulation of the infant may result if the caregiver becomes discouraged and alienated because of unsuccessful feeding experiences or the noxious odor of the regurgitated material.

**PATIENT EDUCATION PROTOCOLS:
FEEDING DISORDERS OF INFANCY OR EARLY CHILDHOOD**

5. Discuss that the inadequate caloric intake noted in Feeding Disorder of Infancy or Early Childhood may exacerbate complications and further contribute to feeding problems, including irritability, difficulty being consoled during feeding, and developmental delays. Infants may appear apathetic and withdrawn.
6. Explain that in some instances, parent-child interaction problems may contribute to or exacerbate the infant's feeding problem (refer to [“FEED-PA Parenting”](#)).

FEED-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in treating or preventing feeding disorders.

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”](#).

FEED-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

FEED-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of the feeding disorders of infancy or early childhood.

STANDARDS:

1. Discuss the symptoms of the specific feeding disorder:

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- a. **Pica** is the persistent eating of nonnutritive substances for a period of at least 1 month which is inappropriate to the developmental level and cultural practice.
 - b. Infants and younger children typically eat paint, plaster, string, hair, or cloth.
 - c. Older children may eat animal droppings, sand, insects, leaves, or pebbles.
 - d. Adolescents and adults may consume sand or clay.
 - e. **Rumination Disorder** is the repeated regurgitation and rechewing of food for a period of at least one month, which is not due to an associated gastrointestinal or other medical condition.
 - f. **Feeding Disorder of Infancy or Early Childhood** is a disturbance as manifested by persistent failure to gain weight or a significant loss of weight over at least one month.
2. Explain that symptoms in infants and young children may also include constipation, excessive crying, excessive sleepiness/ lethargy, and irritability.
 3. Explain that psychosocial problems, such as lack of stimulation, neglect, stressful life situations, and problems in the parent-child relationship may be predisposing factors. Explain that parental aggression, anger, or apathy, as well as lack of nurturing can also increase the risk of feeding disorders.
 4. Explain that the feeding disorders are not caused by a medical condition, such as cleft palate, congenital heart disease, or a disorder that causes mental retardation.
 5. Explain that if these conditions occur exclusively during the course of Anorexia Nervosa, Bulimia Nervosa (refer to **“EAT - Eating Disorders”**), Mental Retardation (refer to **“MR - Mental Retardation”**), or a Pervasive Developmental Disorder (refer to **“PDD - Pervasive Developmental Disorders”**), they must be sufficiently severe to warrant independent clinical attention.

FEED-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care, including well-child visits and mental health professionals.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

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FEED-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding feeding disorders of infancy or early childhood.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding feeding disorders and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

FEED-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of feeding disorders.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

FEED-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

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FEED-L LITERATURE

OUTCOME: The patient/family will receive literature about feeding disorders.

STANDARDS:

1. Provide the patient/family with literature regarding feeding disorders.
2. Discuss the content of the literature.

FEED-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations in caring for an infant and preventing complications.

STANDARDS:

1. Discuss lifestyle adaptations specific to parenting infants who are struggling with potential malnutrition.
2. Discuss that the family may also require lifestyle adaptations to support the caregivers.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

FEED-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

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FEED-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for feeding disorders.

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.

FEED-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to feeding disorders.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

FEED-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce the risk of developing feeding disorders.

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STANDARDS:

1. Discuss that regular well-child visits to the pediatrician can help identify any feeding and growth problems early and can prevent any permanent damage related to malnutrition. Refer to [“FEED-MNT Medical Nutrition Therapy”](#).
2. Discuss the recommended guidelines for nutrition to ensure adequate caloric and fluid intake.
3. Explain the importance of seeking help from a mental health professional to address parenting skills that may assist in improving the condition or preventing exacerbation of complications.

FEED-PA PARENTING

OUTCOME: The patient/family will understand the parenting skills appropriate to meeting the needs of the child(ren).

STANDARDS:

1. Discuss any problems with parent-child interactions that may adversely effect the child's ability to feed appropriately.
2. Discuss the methods for appropriate parenting at home, including the appropriate use of rewards and consequences, and methods for improving the adult-child relationship.
3. Discuss the physical, emotional, and cognitive needs of the child based on age and level of development.
4. Emphasize the importance communicating in a way that the child understands.
5. Discuss the methods for providing emotional support and unconditional assistance to the child.
6. Refer the family to mental health services/family counseling if the family/child(ren) are becoming overwhelmed.

FEED-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of associated conditions of feeding disorders.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.

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5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

FEED-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in coping with the difficulties related to parenting.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in parenting and coping with anger and aggressiveness.
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.

FEED-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain there is no lab test or x-ray to diagnose feeding disorder and tests are usually done to exclude other diagnoses with similar symptoms. It is possible to have a co-existing diagnosis. **Refer to [“FTT - Failure to Thrive \(All Ages\)”](#).**
2. Explain test(s) that have been ordered (explain as appropriate):

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- a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
3. Explain test results:
- a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

FEED-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

FEED-TX TREATMENT

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

STANDARDS:

1. Emphasize the importance of active participation by the parent/family in the development of the treatment plan.
2. Explain that a short period of hospitalization may be required to accomplish goals.
3. Explain that mental health intervention may be useful in addressing the psychosocial problems and parent-child interaction problems (**refer to [“FEED-PA Parenting”](#)**), as well as emotional problems within the family, including

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parental aggression, anger, and apathy. Referral for domestic violence may be indicated (refer to [“DVP - Domestic Violence, Perpetrator”](#)).

4. Explain risk/benefit of treatment and non-treatment.

FASD - Fetal Alcohol Syndrome

FASD-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to fetal alcohol spectrum disorders.

STANDARDS:

1. Explain the normal anatomy and physiology of the brain, heart, lung, kidney as they relate to Fetal Alcohol Spectrum Disorder (FASD).
2. Discuss changes to anatomy and physiology as a result of prenatal exposure to alcohol. People affected by FASD can have brain damage, facial deformities, growth deficits, mental retardation, heart, lung and kidney defects, hyperactivity, attention and memory problems, poor coordination, behavioral problems, and learning disabilities.
3. Discuss the impact of these changes on the patient's health or well-being.

FASD-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 the 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. This may include information about accessing social services, getting medical care, having relationships, shopping, cooking meals, staying out of trouble, structuring leisure time, keeping clean, and using transportation.

FASD-AOD ALCOHOL AND OTHER DRUGS

OUTCOME: The patient/family will understand the importance of avoiding any consumption of alcohol during pregnancy.

STANDARDS:

1. Identify behaviors that reduce the risk for fetal alcohol syndrome.

2. Discuss that consumption of any amount of alcohol during pregnancy can cause FAS or FASD. Emphasize the importance of abstinence from any alcohol use during pregnancy (including beer, wine, liquor, and wine coolers).
3. Explain that FAS and FASD are a cluster of physical, mental, and neurodevelopment 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 to living independently
4. Assist the patient in developing a plan for prevention. Discuss available treatment or intervention options, as appropriate.

FASD-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to FASD.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with FASD as a life-altering illness that requires a change in lifestyle (**refer to [“FASD-LA Lifestyle Adaptations”](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with FASD, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#)**.

6. Refer to a mental health agency or provider.

FASD-C COMPLICATIONS

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

STANDARDS:

1. Discuss that FASD is a unifying term that describes a spectrum of disorders, often co-exists with other diagnoses.
2. Discuss that dysfunctional family dynamics often exists in the homes of persons with FASD.
3. Discuss that growth delay is often a problem with FASD and may require intervention by a registered dietitian.
4. Discuss that persons with FASD are at increased risk of injuries.
5. Discuss that persons with FASD often have problems with learning and behavior at school and other organized activities. The IQ range is 20 to 105 with the average of 68. Prenatal alcohol exposure is the most common nonhereditary cause of mental retardation.
6. Discuss that persons with FASD are at higher risk for being exploited, abused, and neglected.

FASD-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in achieving optimal socialization and education, as well as 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”](#).**
4. Discuss the importance of care coordination for issues on transportation, special education, school, juvenile justice, diagnostic clinics, and parent respite.

FASD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the nature of FASD (Fetal Alcohol Spectrum Disorders), 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 FASD. FASD covers other terms such as fetal alcohol syndrome, alcohol-related neurodevelopmental disorder (ARND), partial fetal alcohol syndrome (PFAS), alcohol-related birth defects (ARBD) and fetal alcohol effects (FAE).
2. Explain that FASD is 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

FASD-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care. Outcomes are better for children with special needs if they have family centered continuity of care, planned care visits, and case management within the concept of the medical home. (See [**FASD-CM Case Management**](#).)
2. Discuss the procedure and process for obtaining follow-up appointments.
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. (See [“FASD-CM Case Management”](#).)

FASD-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 FASD.

STANDARDS:

1. Discuss issues affecting physical growth which may or may not be present, to include abnormal facial features, growth deficits (height, weight, or both), and central nervous system (structural, neurologic, or functional).
2. Discuss factors affecting development. FASD deficits are fixed, and not progressive. There is no cure for FASDs, but research shows that early intervention treatment services can improve a child’s development. Early intervention services help children from birth to 3 years of age (36 months) learn important skills. Services include therapy to help the child talk, walk, and interact with others.

FASD-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding FASD.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding FASD and dealing with issues.
2. Provide the help line phone number or Internet address (URL). Some options to provide information specific to FASD include:
 - a. <http://www.cdc.gov.ncbddd/fasd/>
 - b. <http://www.fasdccenter.samhsa.gov/>
 - c. <http://www.nofas.org/>

FASD-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient will understand lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.

2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high-risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
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.

FASD-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. Information specific to FASD may be found from Center for Disease Control (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), National Institute on Alcohol Abuse and Alcoholism (NIAAA), and National Organization on Fetal Alcohol Syndrome (NOFAS).

FASD-L LITERATURE

OUTCOME: The patient or caregiver will receive literature about FASD.

STANDARDS:

1. Provide patient or caregivers with literature on FASD.
2. Discuss the content of the literature.

FASD-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 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 FASD often requires restructuring the home, community, and school environments.

2. Explain that the interventions for FASD require on-going family/caregiver involvement and continued advocacy for the child.
3. Explain that the use of multiple, consistent, persistent interventions are necessary for a good outcome; communication should be simple, direct, and concrete.
4. Discuss that behavioral and developmental problems associated with FASD may exacerbate parental stress and marital problems. Explain that appropriate help should be sought as soon as the problem is identified.
5. Refer to Social Services, Behavioral Health, Physical Therapy, Speech Therapy, or other rehabilitative services and/or community resources as appropriate.

FASD-MNT MEDICAL NUTRITION THERAPY

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

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.

FASD-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.

FASD-P PREVENTION

OUTCOME: The patient/family will understand that healthy lifestyle behaviors can reduce the risk of fetal alcohol syndrome in unborn children.

STANDARDS:

1. Discuss lifestyle behaviors that increase the risk for fetal alcohol syndrome. No amount of alcohol is safe to drink during pregnancy.
2. Assist the patient in developing a plan for prevention. Complete avoidance of alcohol during the entirety of the pregnancy effectively prevents prenatal alcohol effects. The effective use of birth control or family planning can prevent pregnancy.

FASD-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 FASD. No amount of alcohol is safe to drink during pregnancy.
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.
4. Explain that all women who are pregnant should be screened for alcohol use.

FASD-TE TESTS

OUTCOME: The patient/family/caregiver will understand the importance of diagnosis and the testing process to be performed to diagnose FASD.

STANDARDS:

1. Discuss the benefits of seeking a diagnostic evaluation for FASD.
2. Answer the patient/family questions regarding the evaluation process.
3. Refer to appropriate FASD 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 a small number 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."](#)**

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.
2. Discuss that fever is a symptom, not a disease.
3. Discuss that fever is the body's natural response to infection and that fever helps fight infections by turning on the body's immune system and impeding the spread of the infection.
4. 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.
5. 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. **Refer to ["ABX - Antibiotic Resistance."](#)**

F-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
 - g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

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, becomes lethargic, looks very sick, or develops 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), is over 105°F (40.5°C), or lasts for more than three days.
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](#).**

F-HM HOME MANAGEMENT

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

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 because 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.

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. 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
6. 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.

F-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

F-TX TREATMENT

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

STANDARDS:

1. Discuss that fever can be treated with antipyretics.
2. Explain that fever is a symptom and treating the disease process will resolve the fever.

FMS - Fibromyalgia Syndrome

FMS-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to FMS.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with FMS as a life-altering illness that requires a change in lifestyle (**refer to [“FMS-LA Lifestyle Adaptations”](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with FMS, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#)**.
6. Refer to a mental health agency or provider.

FMS-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

FMS-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and prognosis of fibromyalgia.

STANDARDS:

1. Discuss that the exact cause of fibromyalgia syndrome (FMS) is unknown. Explain FMS is characterized by widespread musculoskeletal pain often accompanied by:
 - a. fatigue and sleep disturbances
 - b. stiffness, and tenderness of muscles, tendons, and joints
 - c. problems with thinking and memory (“fibro fog”)
 - d. exercise difficulties related to increased pain sensitivity
 - e. headaches including migraines
 - f. sensation of numbness in hands and feet
2. Explain that there is currently no specific test for FMS and that the diagnosis is made by symptom history and physical exam. Discuss that the onset of FMS has been associated with physical or emotional trauma and infections/illness.
3. Discuss the patient’s specific conditions, including anatomy and physiology as appropriate. Discuss any associated conditions. Discuss any associated conditions and risk factors for FMS:
 - a. Gender: FMS is diagnosed more often in women than in men.
 - b. Family history: the patient may be more likely to develop FMS if a relative also has the condition.
 - c. Rheumatic disease: if you have a disease such as rheumatoid arthritis or systemic lupus erythematosus the patient may be more likely to develop FMS.
4. Explain that FMS symptoms vary in location and severity from day-to-day and does not cause deformities nor is it life threatening. Explain certain factors can contribute to symptom flare-ups:
 - a. cold or drafty environments
 - b. hormonal fluctuations (premenstrual and menopausal)
 - c. stress, depression, or anxiety
 - d. over exertion
 - e. infections

FMS-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in enhancing physical and psychological well-being.

STANDARDS:

1. Explain that low impact aerobic activity, stretching or gentle physical activity programs boosts energy, helps relieve pain and reduce anxiety, stress, and depression.

2. Encourage the patient to start slow and build up physical activity tolerance in small increments, avoiding over-exertion.
3. Assist the patient in developing a personal physical activity plan; some examples are walking, tread mill, stretching, swimming in warm water, or pace programs from the arthritis foundations.
4. Discuss obstacles to a personal exercise plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
5. Discuss medical clearance issues for physical activity.

FMS-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of fibromyalgia syndrome (FMS).

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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 (i.e, behavioral health, registered dietitian, physical therapy).

FMS-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding FMS.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding FMS and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

FMS-L LITERATURE

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

STANDARDS:

1. Provide the 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 fibromyalgia syndrome (FMS).

STANDARDS:

1. Explain that the patient has a responsibility to make lifestyle adaptations to relieve or control symptoms. It is a process of making wise choices and changes that will positively affect the overall state of health.
2. Emphasize the importance getting enough sleep, pacing activities to avoid fatigue, regular exercise, and learning to cope with mental and physical stress.
3. Discuss the use of heat and cold as appropriate.
4. Review the areas that may require adaptations to maintain a healthy lifestyle: diet, physical activity, sexual activity, and bladder/bowel habits.
5. Discuss ways to improve communication with family, friends, and caregivers to understand the patient's needs related to employment and family stress. **Refer to ["FMS-BH Behavioral and Emotional Health"](#).**

FMS-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication(s) for fibromyalgia syndrome (FMS).

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication. Common medications used in the treatment of FMS are analgesics, anti-inflammatory and anti-depressants, muscle relaxants, pain patches, or trigger point injections. Narcotics (opioids) are controversial and may require chronic pain management.
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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

FMS-MNT MEDICAL NUTRITION THERAPY

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

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-N NUTRITION

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

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Explain that a weight-loss plan may be beneficial if overweight.
6. Refer to a Registered Dietitian for MNT or other local resources as appropriate.

FMS-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand pain management techniques.

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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic pain control measures such as:
 - a. Massage therapy, biofeedback, relaxation training
 - b. Chiropractic, yea, and Tai Chi
 - c. Traditional healing
 - d. Myofascial release
 - e. Trigger point therapy
 - f. Gentle stretching and low impact activity
 - g. Occupational therapy

FMS-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of fibromyalgia syndrome.

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. Explain that cognitive/behavioral therapy and operant behavior therapy are effective in managing the concurrent hopelessness, negative thinking, and victim mentality which can be barriers to treatment.
3. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

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 and interferes with the treatment of chronic pain of FMS. This can set up a cycle of pain-stress which becomes self-sustaining and may escalate.
2. Discuss that in chronic pain, uncontrolled stress may lead to depression or other mood disorders. Refer to [“CPM-PSY Psychotherapy”](#).
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 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, while setting realistic goals
 - c. Talking with people you trust about your worries or problems
 - d. Getting enough sleep
 - e. Maintaining a healthy diet
 - f. Exercising regularly
 - g. Taking vacations
 - h. Practicing meditation, self-hypnosis, and positive imagery
 - i. Practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
 - j. Participating in spiritual or cultural activities
6. 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 that there is no lab test or x-ray to diagnose FMS, and tests are usually done to exclude other diagnoses with similar symptoms, e.g., thyroid disease, arthritis, multiple sclerosis, or lupus. It is possible to have a co-existing diagnosis.

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.

FMS-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.
5. Explain that cognitive/behavioral therapy and operant behavior therapy are effective in managing the concurrent hopelessness, negative thinking, and victim mentality which can be barriers to treatment. **Refer to [“FMS-PSY Psychotherapy”](#).**

FOOT - Foot/Podiatric Disorders

FOOT-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of the foot.
2. Discuss the changes to anatomy and physiology as a result of foot disorder (e.g., skin changes, nerve damage, deformities, amputations).
3. Discuss the impact of these changes on the patient's health or well-being (e.g., deformity, amputation).

FOOT-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of the patient's foot disorder.

STANDARDS:

1. Discuss the common or significant complications associated with the foot disorder, e.g., pain, itchy rashes, serious infections, amputations, and nerve damage.
2. Describe the signs/symptoms of common complications, e.g., numbness, tingling, pain, open sores, smelly wounds, itching, cracking. Refer to [“DM-FTC Foot Care And Examinations.”](#)
3. Discuss that many complications can be prevented by full participation with the treatment plan.

FOOT-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the foot disorder.

STANDARDS:

1. Discuss the foot disorder. Refer to [“DM-FTC Foot Care And Examinations.”](#)
2. Explain causative factors and implications of the foot disorder.
3. Discuss the signs/symptoms and usual progression of the foot disorder.
4. Discuss the signs/symptoms of exacerbation/worsening of the foot disorder.

FOOT-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow up care in the treatment of foot disorders.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow up appointments.
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.

FOOT-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of the patient's foot disorder.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan. Refer to [“DM-FTC Foot Care And Examinations.”](#)
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.

FOOT-HY HYGIENE

OUTCOME: The patient will understand personal routine hygiene as it relates to foot health.

STANDARDS:

1. Discuss bathing and foot hygiene habits (e.g., daily foot inspection, washing, nail clipping, bathroom cleanliness).
2. Discuss any hygiene habits that are specifically pertinent to the foot disorder or dressing changes.
3. Explain that protective footwear may be necessary. Refer to [“DM-FTC Foot Care And Examinations.”](#)

FOOT-L LITERATURE

OUTCOME: The patient/family will receive literature about the patient's foot disorder.

STANDARDS:

1. Provide the patient/family with literature on the foot disorder.

2. Discuss the content of the literature.

FOOT-M MEDICATIONS

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

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

FOOT-P PREVENTION

OUTCOME: The patient/family will understand that healthy lifestyle behaviors can reduce the risk of developing foot disorders and/or complications.

STANDARDS:

1. Discuss the importance of good shoes and socks for foot health (support, breathability, wicking). Shoes should fit properly without pinching, slipping, rubbing, or pressure spots.
2. Discuss healthy lifestyle habits that will prevent/control conditions that may predispose to a foot disorder, e.g., wearing proper shoes, tobacco cessation, healthy eating, exercise and stretching prior to exercise.
3. Discuss the importance of foot exams (e.g., home foot checks, yearly filament screening). Refer to [“DM-FTC Foot Care And Examinations.”](#)
4. List lifestyle habits that increase/decrease the risk for the onset, progression, or spread of the foot disorder

FOOT-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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
5. Explain non-pharmacologic measures that may be helpful with pain control.

FOOT-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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

FOOT-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):

- a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

FOOT-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 participation with treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.
5. Refer to a foot specialist as appropriate.

FOOT-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 wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound. As appropriate the patient/family will demonstrate the necessary wound care techniques.

4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound. Refer to [**“DM-FTC Foot Care And Examinations.”**](#)

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. Discuss that formula feeding a premature infant is different from feeding a term infant.
 - a. A premature infant may be sleepy at feeding times, may not be strong enough to drink enough milk to sustain growth, and may have a difficult time swallowing and breathing at the same time.
 - b. The skills to promote successful formula feeding in premature infants are, for example, sit the baby up, use chin and cheek support, exercise the infant's mouth to strengthen muscles.
2. Explain the importance of selecting an age appropriate nipple that is comfortable to baby's mouth in order to feed formula at a rate that the baby can manage.
3. Discuss infant feeding techniques, such as:
 - a. the proper angle during feeding
 - b. the dangers associated with propping bottles are, for example, increased risk of choking, tooth decay, and increased risk of ear infection
4. Explain that the choice between plastic and glass bottles is up to the parents. Glass is easy to clean, dries quickly, and holds temperature better than plastic.
5. Explain the types of formulas available.
 - a. Encourage a formula that meets the baby's individual needs.
 - b. Discuss that most infants require iron fortified formulas for brain growth.
6. Discuss signs and symptoms of formula intolerance:
 - a. Frequent stomachaches or vomiting, cough, runny nose and wheezing, skin itching, and rash are examples of formula intolerance or allergy.
 - b. 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.

FF-HELP **HELP LINE**

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding infant formula feeding.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding infant formula feeding and dealing with feeding issues.
2. Discuss services available from WIC programs and other local services.
3. Provide the help line phone number or Internet address (URL).

FF-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to infant formula feeding.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
2. Review the importance of age-appropriate oral hygiene.
3. Review the risks of exposing infants to communicable diseases.

FF-L LITERATURE

OUTCOME: The parents/family will receive literature about formula feeding.

STANDARDS:

1. Provide the parent(s) and family with literature on formula feeding.
2. Discuss the content of the literature.

FF-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for infant feeding.

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 status and related conditions
 - b. identification of nutritional problems
 - c. identification of a specific nutrition intervention therapy plan
 - d. evaluation of nutritional care outcomes.

- e. reassessment as needed
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition 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/family will understand nutrition, as it relates to formula feeding.

STANDARDS:

1. Review the infant's specific age-related nutritional needs.
 - a. Discuss the recommended frequency and amounts of formula for the infant's individual needs.
 - b. Instruct parents to check with the infant's primary care provider before switching formula type.
2. Discuss current nutritional habits. Assist the parent in identifying unhealthy nutritional habits.
3. Emphasize the importance of infant receiving formula up to the age of 1 year.
Refer to ["CHN-N Nutrition"](#).
4. Emphasize the importance of full participation to the prescribed nutritional plan.
5. Explain that a formula fed baby over 6 months of age may need a fluoride supplement if the water used to prepare the formula is un-fluoridated tap water, bottled water, or filtered water.
6. Explain the dangers of giving feeding goat/cow milk before age of one year.

FF-S SAFETY

OUTCOME: The parents/family will understand safety as it relates to preparing, feeding, and storing formula.

STANDARDS:

1. Explain that babies during the first three months of age have low resistance to bacteria. Boiling water for five minutes before mixing formula may be necessary. This applies to all water sources.
2. Explain that boiling bottles and nipples for five minutes, washing with hot, soapy water, and/or using a dishwasher before use is also recommended. Explain that bottle liners must be discarded after each use, and discard bottle nipples that are old, soft, cracked, or discolored.

3. Explain that following manufactures instructions for mixing formula is extremely important and also using recommended measuring cups and spoons.
4. Explain that bottles should be prepared one at a time or in small batches, labeled, covered, refrigerated, and used within 48 hours. Discard any unused formula after each feeding and then wash the bottle immediately.
5. Explain that warming a formula bottle is best done under warm, running tap water. Do not use a microwave oven to warm formula bottles.
6. Explain the possibility of exposure to toxins, such as lead, in the water source.

FRST - Frostbite

FRST-C **COMPLICATIONS**

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

STANDARDS:

1. Explain that frostbitten 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 frostbite or wound infections (e.g., cellulitis) or generalized infection, e.g., loss of appendage, skin grafting.
4. Explain that scarring and/or tissue discoloration are common after healing of frostbite.
5. Emphasize the importance of early treatment to prevent complications.
6. Emphasize the importance to avoid thawing and then refreezing the injury. This is very dangerous and can cause serious consequences.

FRST-CUL **CULTURAL/SPIRITUAL ASPECTS OF HEALTH**

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

STANDARDS:

1. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are interactions or contraindications with the condition or prescribed treatment.
2. 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 traditional remedies, such as sweat lodges, may affect some conditions in detrimental ways.

FRST-DP **DISEASE PROCESS**

OUTCOME: The patient/family will understand how frostbite occurs, the signs and symptoms of frostbite, and the 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 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.
3. Explain that frostbite can occur in a matter of minutes and the most common parts of the body affected by frostbite include the hands, feet, ears, nose, and face. 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.
4. Explain that the following conditions predispose to frostbite:
 - a. Exposure of the body to cold temperature, high altitude, humidity, and wind-chill
 - b. Wearing wet clothing and shoes
 - c. Ingestion of alcohol and other drugs

FRST-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

FRST-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high-risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
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.

FRST-L LITERATURE

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

STANDARDS:

1. Provide the 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. 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

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. Discuss that it is important to wear dry, loose, layered, wind proof clothing (e.g., hat, gloves, loosely fitting layered clothing).
3. Discuss the importance to stocking the vehicle appropriately for winter travel (e.g., blankets, gloves, hats, water).
4. Discuss that remaining physically active can significantly reduce the risk of suffering from frostbite.
5. Review the sensations of early signs of frostbite, e.g., sensations of intermittent stinging, burning, throbbing, and aching are all early signs of frostbite. Get indoors.
6. Explain that the following people are at greater risk to frostbite, as appropriate:
 - 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 warm climates

FRST-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand how to manage the pain associated with frostbite.

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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Discuss non-pharmacological measures that may be helpful with pain control, e.g., warm or cool packs.

FRST-TX TREATMENT

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

STANDARDS:

1. Discuss the goal of treatment; prevention of further exposure to affected area(s), management and prevention of complications.
2. Emphasize that it is optimal to have frostbite injuries re-warmed under medical supervision.
3. Explain that the patient needs to stay warm after thawing. Refreezing can cause more severe tissue damage.
4. Review proper thawing process:
 - a. Use warm-to-the touch water 100°F (38°C) for 30–45 minutes until a good color (flush) has returned to the entire area. Emphasize that this process may be painful, especially the final few minutes.
 - b. Leave the blisters intact. Cover with a sterile or clean covering if protection is needed to prevent rupturing of blisters.
 - c. Keep the affected part(s) as clean as possible to reduce the risk of infection.
 - d. Keep the affected area elevated above the level of the heart.
5. Emphasize the importance of having a current tetanus booster.
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. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

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

OUTCOME: The patient will understand anatomy and physiology as it relates to gallbladder disorders.

STANDARDS:

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

GB-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to gallbladder disorders.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with gallbladder disorders as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with gallbladder disorders, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).**
6. Refer to a mental health agency or provider.

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. Describe the signs/symptoms of common complications of gallbladder disease:
 - a. 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.
 - b. Empyema of the gallbladder (pus in the gallbladder) is a serious complication of acute cholecystitis and can result in death. Empyema is relatively rare.
 - c. 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](#).**
2. Explain that risk of serious complications can be reduced by seeking prompt medical attention.

GB-DP DISEASE PROCESS

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

STANDARDS:

1. 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
2. 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.

Explain that gallstones in the common bile duct can also result in jaundice or pancreatitis.

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 changing position, taking 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.
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.

GB-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

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 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

GB-MNT MEDICAL NUTRITION THERAPY

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

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 nutrition in gallbladder disease.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.

2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Explain that a diet that is high in fat and simple sugars can contribute to the formation of gallstones.
4. Explain that rapid weight loss should be avoided because it may contribute to formation of gallstones.

GB-P PREVENTION

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

STANDARDS:

1. Explain that maintaining a normal body weight and eating a diet low in fats/calories is key to reducing the risk of gallstones and gallbladder disease.
2. 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 and fully participate in 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 in gallbladder disease is specific to the disease process of this particular patient and may be multifaceted. **Refer to [“PM - Pain Management”](#).**
 - a. often antispasmodics may be helpful
 - b. short term use of narcotics may be helpful
 - c. other medications may be helpful to control pain and the symptoms of nausea and vomiting
 - d. administration of fluids may help with pain relief and resolution of symptoms
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

GB-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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

GB-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results

- c. how results will impact or effect the treatment plan
- d. recommendations based on the test results

GB-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

GE - Gastroenteritis

GE-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

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 that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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/family will understand the importance of follow-up in the treatment of gastroenteritis.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

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 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 on 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. Discuss 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 understand the specific nutritional intervention(s) needed for treatment or management of gastroenteritis.

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.) Discourage the use of juices because many of them will make the diarrhea worse. Discourage the use of caffeinated beverages because they are dehydrating.
4. 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.
5. 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 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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
5. Explain non-pharmacologic measures that may be helpful with pain control.

GE-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand the anatomy and physiology as it relates to gastroesophageal reflux disease.

STANDARDS:

1. Explain the normal anatomy and physiology of the stomach, esophagus, and upper airway.
2. Discuss the changes to anatomy and physiology as a result of reflux.
3. Discuss the impact of these changes on the patient's health or well-being.

GER-C COMPLICATIONS

OUTCOME: The patient/family will understand common and important complications of gastroesophageal reflux disease.

STANDARDS:

1. Discuss common complications of gastroesophageal reflux disease.
2. Describe the signs/symptoms of common complications of gastroesophageal reflux disease that should prompt immediate follow-up.

GER-CM CASE MANAGEMENT

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

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"](#).**

GER-DP DISEASE PROCESS

OUTCOME: The patient will understand the disease process 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-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in gastroesophageal reflux disease.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

GER-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

GER-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

GER-L LITERATURE

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

STANDARDS:

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

GER-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/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”](#).
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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

GER-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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 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 may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as 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, 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 test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

GER-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

GENDR - Gender Identity Disorder

GENDR-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications associated with gender identity disorder.

STANDARDS:

1. Discuss common complications of cross gender identification, which manifests differently across the life cycle.
2. Describe the common complications of gender identity disorder, including school aversion or dropping out of school, failure to develop age-appropriate same-sex peer relationships and skills, low self-esteem, and peer ostracism.
3. Explain that individuals with gender identity disorder often develop depression (**refer to [“DEP - Depressive Disorders”](#)**) and anxiety, which would benefit from mental health interventions.
4. Discuss the common social difficulty in cross-sex identification, and the potential for isolation, bullying, and ostracism, especially in adolescence, and which can result in suicide or serious suicidal ideation (**refer to [“SI - Suicidal Ideation and Gestures”](#)**).
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#)**.

GENDR-CM CASE MANAGEMENT

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

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”](#)**.

GENDR-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/ceremonies may be useful in conjunction with other healthcare modalities in achieving optimal health.

GENDR-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the gender identity disorder.

STANDARDS:

1. Explain that gender identity disorder, also known as transsexualism or transgender, is a conflict between a person's actual physical gender and the one that one actually identifies with.
2. Discuss the essential features of gender identity disorder:
 - a. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
 - i. In children, the disturbance is manifested by a repeated desire to be, or insistence that one is, the other sex, a preference for cross-dressing, strong preferences for cross-sex roles in imaginative play, fantasies of being the other sex, and preferences for playmates of the opposite sex.
 - ii. In adolescents and adults, the disturbance is manifested by symptoms, such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or a conviction that one has the typical feelings and reactions of the other sex.
 - b. A persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex.
 - i. In children, the disturbance is manifested by disgust of one's own genitalia or aversion toward normative sex-role play, clothing, or developmental milestones, such as menstruation or gender appropriate practices (e.g. girls' rejection of urinating in a sitting position).
 - ii. In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g. request for hormones, surgery, or other procedures to physically alter the sexual characteristics to simulate the other sex), or belief that one was born the wrong sex.
3. Explain that individuals with gender identity disorder have normal genitalia, and that the disturbance is not concurrent with a physical intersex condition.
4. Explain that the disorder may affect choice of sexual partners, display of feminine or masculine mannerisms, behavior, and dress, and self-concept.

5. Explain that the course of the disorder involves many variations and fluctuations throughout the lifespan:
 - a. Only a small number of children that meet criteria for gender identity disorder will continue to have the symptoms into adolescence and adulthood. The symptoms become less overt over time for most individuals, and most diagnosed children later report a homosexual or bi-sexual orientation.
 - b. Individuals who present with symptoms in adolescence or adulthood, the course may appear more gradually, and are less likely to be satisfied with sex-reassignment surgery.
 - c. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

GENDR-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

GENDR-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding gender identity disorder.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding gender identity disorder and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

GENDR-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

GENDR-L LITERATURE

OUTCOME: The patient/family will receive literature about gender identity disorder.

STANDARDS:

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

GENDR-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for gender identity disorder.

STANDARDS:

1. Discuss lifestyle adaptations necessary for adjusting to social, occupational, and other pressures.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

GENDR-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

GENDR-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of gender identity disorder.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

GENDR-S SAFETY

OUTCOME: The patient/family will understand safety plan when severe bullying and suicidal thoughts are present.

STANDARDS:

1. Discuss/review the safety plan with the patient and family, including the no-harm contract and emergency procedures should the condition worsen, should suicidal or homicidal ideation arise, or should the patient feel urges to engage in risky/ dangerous behavior.
2. Explain that local police may also be available to assist in transportation and safety compliance.

GENDR-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in coping with gender identity disorder.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in coping with gender identity disorder.
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.

GENDR-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

GENDR-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options for gender identity disorder.

STANDARDS:

1. Explain the treatment for gender identity disorder is usually directed toward associated conditions, including depression, anxiety, and coping with social problems.
2. Explain that hormone and sex re-assignment therapies are controversial treatment options, and that identity issues are not usually resolved by these treatments.
3. Explain that therapists have different styles and orientations for treating gender identity disorder, and that some styles may suit the patient and family better than others. Explain that the strategies may include individual and family therapy for children, and individual and couple's counseling for adults.
4. Explain that medications may also be prescribed to treat comorbid conditions, such as depression and anxiety (**refer to ["GENDR-M Medications"](#)**).
5. Explain that the treatment plan will be made by the patient, parents, and the treatment team after reviewing available options. Explain that treatment for gender identity disorder may vary according to the patient's life circumstances, severity of the condition, the family's participation in the intervention, and available resources.

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 generalized anxiety disorder can cause major disruptions in social or occupation functioning.
2. Discuss that generalized anxiety disorder can cause psychosomatic 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 generalized anxiety disorder may worsen and develop into depression (refer to [“DEP - Depressive Disorders”](#)), other anxiety disorders, and suicidal ideation (refer to [“SI - Suicidal Ideation and Gestures”](#)).
4. Discuss the high incidence of substance abuse/dependence as a co-morbid condition with generalized anxiety disorder (refer to [“AOD - Alcohol and Other Drugs”](#)).

GAD-CM CASE MANAGEMENT

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

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”](#).

GAD-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

GAD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of generalized anxiety disorder.

STANDARDS:

1. Explain that generalized anxiety disorder is characterized by severe anxiety and fear which is not attributable to a specific stressor and is significant enough to interfere with work, home, or social functioning.
2. Explain that the essential features of generalized anxiety disorder is excessive anxiety and uncontrollable worry even about ordinary or routine activities, and is associated with symptoms of hyper-arousal, including:
 - a. restlessness/feeling keyed up
 - b. muscle tension
 - c. irritability
 - d. difficulty concentrating
 - e. disturbed sleep
 - f. an unusual number of physical complaints for which a source cannot be found
3. Explain that the intensity, duration, and frequency of the anxiety and worry are far out of proportion to the actual likelihood or impact of the feared event.
4. Discuss that in many cases, generalized anxiety disorder is a neurochemical/ biological disorder and may not be the result of the patient's personality or inappropriate coping mechanisms.
5. Explain that the symptoms of generalized anxiety disorder may fluctuate at times. It can worsen when the patient is more stressed, but may not be related to outside stressors. Explain that there is a tendency for generalized anxiety disorder to worsen over time if left untreated, but there are effective treatments available.
Refer to ["GAD-TX Treatment"](#).

GAD-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in the treatment of generalized anxiety disorder.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

GAD-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

GAD-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding generalized anxiety disorder.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding generalized anxiety disorder and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

GAD-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high-risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

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 the patient/family with literature on generalized anxiety disorder.
2. Discuss the content of the literature.

GAD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for generalized anxiety disorder.

STANDARDS:

1. Discuss lifestyle adaptations specific to coping with chronic anxiety, including the reduction or elimination of stimulants, the avoidance sedating drugs and alcohol, and getting regular sleep and exercise.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

GAD-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of generalized anxiety disorder.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.

6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

GAD-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress 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-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

GAD-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options that may be used to treat anxiety.

STANDARDS:

1. Explain that a combination of psychotherapy and medication interventions usually has better results than therapy or medication alone. Explain that the patient has a right to choose either option or both, and that the patient's active participation in the treatment decisions is critical to a good outcome.
2. Discuss the treatment plan which may include a combination of psychotherapy, pharmacologic, and lifestyle adaptation.
 - a. Some therapists have different styles and orientations for treating generalized anxiety disorder, although some styles may suit the patient better.
 - b. Counseling or psychotherapy is an effective treatment for generalized anxiety disorder, and the length of therapy varies according to the patient's needs.
 - c. Medication may be prescribed on an individualized basis to manage symptoms of anxiety. Discuss the risk of dependence to the medication, as appropriate. Refer to ["GAD-M Medications"](#).
3. Explain that the treatment plan will be made by the patient and treatment team after reviewing available options. Explain that treatment for generalized anxiety disorder may vary according to the patient's life circumstances, severity of the condition, and available resources.
4. Discuss the importance of fully participating in the treatment plan, including scheduled follow-up.

GENE - Genetic Disorders

GENE-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to this specific genetic disorder.

STANDARDS:

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

GENE-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to this genetic disorder.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with this genetic disorder as a life-altering illness that requires a change in lifestyle (refer to [“GENE-LA Lifestyle Adaptations”](#)).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with this genetic disorder, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. Refer to [“AOD - Alcohol and Other Drugs”](#).
6. Refer to a mental health agency or provider.

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”](#).

GENE-DP DISEASE PROCESS

OUTCOME: The patient/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-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device

2. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

GENE-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

GENE-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of this genetic disorder.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

GENE-L LITERATURE

OUTCOME: The parents/family will receive literature about the genetic disorder.

STANDARDS:

1. Provide the parents/family with literature on 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 that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life. 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).
4. Refer to community services, resources, or support groups, as available.

GENE-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

GENE-MNT MEDICAL NUTRITION THERAPY

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

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).
2. Discuss the need for consistent parenting especially in children with special needs.

3. Discuss the need for respite care (alternative caregivers) to allow for time for the parents to have time for themselves.

GENE-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

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

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. exercising regularly
 - 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.

GENE-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

GDM - Gestational Diabetes

GDM-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to gestational diabetes mellitus (GDM).

STANDARDS:

1. Explain the anatomy and physiology of GDM.
2. Discuss the changes to anatomy and physiology as a result of GDM.
3. Discuss the impact of these changes on the patient's health or well-being, and the impact of these changes on the growth and development of the unborn infant.

GDM-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to gestational diabetes mellitus.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with gestational diabetes mellitus as a life-altering illness that requires a change in lifestyle (**refer to [“GDM-LA Lifestyle Adaptations](#)”).**
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with gestational diabetes mellitus, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).**
6. Refer to a mental health agency or provider.

GDM-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of gestational diabetes mellitus for mother and unborn baby.

STANDARDS:

1. Explain that uncontrolled GDM can result in the following complications for the infant: macrosomia, hypoglycemia, respiratory distress, hypocalcemia, shoulder dystocia, hyperbilirubinemia, still birth or fetal damage,
2. Explain that uncontrolled GDM can result in the following complications for the mother: hyperglycemia, miscarriage, preeclampsia, C-section, and increase risk of GDM with subsequent pregnancies and onset for diabetes mellitus type 2.

GDM-CM CASE MANAGEMENT

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

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”](#).**
4. Discuss programs such as Sweet Success whose goal is to improve pregnancy outcomes for women and their infants when pregnancies are complicated by diabetes. Refer as appropriate.

GDM-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences that cultural and spiritual traditions, practices, and beliefs contribute during pregnancy in a patient with gestational diabetes mellitus.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining blood sugar control. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

GDM-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the disease process of gestational diabetes mellitus.

STANDARDS:

1. Briefly describe the disease process of GDM, including insulin resistance and hormonal changes, as appropriate.
2. Describe risk factors for developing GDM, e.g., family history of diabetes, age, ethnicity, previous GDM pregnancy, sedentary lifestyle, overweight.
3. Explain that the symptoms of GDM are similar to normal pregnancy and screening is required. These signs/symptoms may include: increased thirst, increased urination, increased hunger, unintentional weight loss, lethargy, headache, blurry vision, impaired concentration, impaired wound healing and immune response.
4. Emphasize that there is no cure for GDM. Encourage screening at 26 to 28 weeks.

GDM-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity during pregnancy.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being especially during labor and delivery, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss barriers to a personal physical activity plan and solutions to those barriers. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Discuss the availability of community resources and refer as appropriate.

GDM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in gestational diabetes mellitus.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

GDM-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss the benefits of breastfeeding in reducing the risk for diabetes in both mom and infant.
4. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
5. Review the community resources available for help in achieving behavior changes.

GDM-L LITERATURE

OUTCOME: The patient/family will receive literature about gestational diabetes mellitus.

STANDARDS:

1. Provide the patient/family with literature on gestational diabetes mellitus.
2. Discuss the content of the literature.

GDM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for gestational diabetes mellitus.

STANDARDS:

1. Discuss lifestyle adaptations are the key components to preventing or delaying the progression of GDM.
2. Emphasize that nutrition and physical activity are critical components in addressing insulin resistance.
3. Explain that while medications may help, lifestyle adaptations are the key to improving health.
4. Explain that use of tobacco products can exacerbate the disease process and lead to complications.

GDM-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. Discuss the use of medicine during pregnancy.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

GDM-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for gestational diabetes mellitus.

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. Discuss the availability of community resources and refer as appropriate.

GDM-N NUTRITION

OUTCOME: The patient/family will understand the importance of nutritional management in gestational diabetes mellitus.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Identify techniques or strategies for eating out, social events, traditional eating practices, and family support in monitoring blood sugar.
4. Explain that emotional eating from boredom, anger, frustration, loneliness, and depression can interfere with blood sugar control, as appropriate. Alternative choices should be recommended.
5. Discuss managing food intake with medication on sick days and with physical activity to prevent hypoglycemia.
6. Discuss the need for nutritional intervention and refer to a Registered Dietitian as appropriate.

GDM-PRO PROCEDURE

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 of 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 for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent

- b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

GDM-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. **Refer to [“AF-REF Referral Process.”](#)**
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

GDM-SCR SCREENING

OUTCOME: The patient/family will understand the proposed screening including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed screening, e.g., blood pressure, blood sugar, development, mental health.
2. Explain the process and what to expect after the screening.
3. Emphasize the importance of follow-up care.

GDM-SHS SECOND-HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Explain that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, carcinogens.

3. Explain the increased risk of illness when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia, SIDS, and lung cancer.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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.

GDM-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in gestational 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 GDM.
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 GDM.
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, 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. Discuss the availability of community resources and refer as appropriate.

GDM-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 (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

GIB - GI Bleed

GIB-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of the gastrointestinal tract as it relates to this patient.
2. Discuss the changes to anatomy and physiology that result in gastrointestinal bleeding.
3. Discuss the impact of these changes on the patient's health or well-being.

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 that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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 GI bleeding can be caused by an infection of the stomach that may require treatment with antibiotics.
3. Explain that the bleeding may present itself in a variety of ways, depending on the source and severity of the bleeding.
4. 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 understand and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
 - g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

GIB-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

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 on the disease process involved with the gastrointestinal bleeding.
2. Discuss the content of the literature.

GIB-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

GIB-MNT MEDICAL NUTRITION THERAPY

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

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. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
 - a. certain foods are likely to exacerbate the GI condition and should be avoided, e.g., alcohol, caffeine, fatty foods
 - b. bland starchy foods are easier to digest and may be more easily tolerated
 - c. consumption of yogurt (with live or active cultures) is often helpful to resume normal bowel flora
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Explain that rest of the gastrointestinal tract may be required in the immediate GI bleed period and that IV nutrition support may be necessary if prolonged abstinence from food is required. Explain that gradual introduction of oral nutrients will be accomplished while decreasing IV nutrition support. Bowel irregularity is common during this period of time. Refer to a registered dietician for MNT.

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, and steroids, which might aggravate or precipitate bleeding.
2. Emphasize the importance of regular bowel movements in the prevention of GI bleeds.

GIB-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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

GIB-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in gastrointestinal bleeding.

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.

GIB-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

GIB-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

GL - Glaucoma

GL-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

GL-C COMPLICATIONS

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

STANDARDS:

1. Discuss common complications of glaucoma.
2. Describe the signs/symptoms of common complications of 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 in early open-angle glaucoma there are usually no symptoms. Acute-angle closure glaucoma may occur at any age and may include eye pain, light sensitivity, blurred vision, halos, or nausea and vomiting.
3. Explain that untreated glaucoma will result in permanent loss of vision due to optic nerve damage. Discuss the status of the ocular condition and the potential to maintain, lose, or regain the quality of ocular health and visual capabilities.

GL-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of follow-up in the treatment of glaucoma.

STANDARDS:

1. Emphasize the importance of follow-up care. Discuss that frequent examinations are required to monitor for side effects of treatment or disease progression.
2. Discuss the procedure and process for obtaining follow-up appointments.

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.

GL-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding Glaucoma.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding Glaucoma and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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/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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

GL-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

GL-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing

- b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

GL-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

GOUT - Gout (Inflammatory Arthritis)

GOUT-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of the joints.
2. Discuss the changes to anatomy and physiology as a result of gout (inflammatory arthritis).
3. Discuss the impact of these changes on the patient's health or well-being.

GOUT-C COMPLICATIONS

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

STANDARDS:

1. Discuss common complications of hyperuricemia (uric acid).
2. Describe the signs/symptoms of common complications of gout.

GOUT-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

GOUT-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the gout.

STANDARDS:

1. Review the disease process of gout. Gout is caused by inflammation when uric acid crystals are deposited in connective tissue and/or in the fluid that cushions a

joint (the synovial fluid). Uric acid can build up in the blood when the body produces too much uric acid or if the kidneys don't eliminate enough of it.

2. Discuss that gout is the most common form of inflammatory arthritis in men over 40 and affects approximately 3 times as many men as women.
3. Explain that a gout attack and or flare up usually starts with sudden, severe pain, tenderness, redness, warmth, and swelling in a joint. The attacks/flare last about 3-10 days, the attack usually subsides, and the next one may not happen for months or even years.
4. Explain that a gout attack/flare up can not be predicted for someone with hyperuricemia. The attack can be triggered by food, alcohol, certain medications, illness.
5. Explain that gout can progress, eventually causing damage to joints, and possible disability.

GOUT-EX EXERCISE

OUTCOME: The patient/family will maintain an optimal level of mobility with minimal discomfort while exercising when gout is present.

STANDARDS:

1. Refer to medical provider for release before exercising with gout. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
2. Assist the patient in developing a personal physical activity plan and discuss the appropriate frequency, intensity, time, and type of activity.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Emphasize the importance of “warm-ups and cool-downs.” Caution the patient not to overexert during gout flare ups.
5. Refer to community resources as appropriate.

GOUT-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

GOUT-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of gout.

STANDARDS:

1. Explain the home management techniques.
2. Discuss appropriate foot wear and clothing. Refer to [“FOOT - Foot/Podiatric Disorders”](#), as appropriate.
3. Discuss the implementation of hygiene and infection control measures.
4. Refer to community resources, hospice, or support groups, as appropriate.

GOUT-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

GOUT-L LITERATURE

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

STANDARDS:

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

GOUT-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary to optimize performance during attack/flare up of gout.

STANDARDS:

1. Discuss lifestyle adaptations specific to gout.
2. Discuss that family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

GOUT-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

GOUT-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for gout.

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.

GOUT-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to gout.

STANDARDS:

1. Review weight management with your health care providers since obesity is one of the several conditions commonly associated with gout.
2. Discuss the importance of regular meals and adequate fluid intake.
3. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating for basic healthy dietary changes. Avoid purine containing foods e.g. cheeses and processed meats.
4. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food label.
5. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
6. Refer to registered dietitian for MNT or other local resources as appropriate.

GOUT-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of developing gout flare ups.

STANDARDS:

1. Discuss weight management and stress management.
2. Emphasize dietary modification, especially avoiding alcohol and avoiding purine containing foods.

GOUT-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

GOUT-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

GOUT-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to injury prevention and will implement necessary measures to avoid injury.

STANDARDS:

1. Explain ways to adapt the home to improve safety and prevent injuries, such as remove throw rugs, install safety bars in hallways and near stairs.
2. Explain the importance and proper use of mobility devices (can, walker, electric scooters, wheel chair).
3. Explain the importance of safety factors while being mobile outdoors during different weather conditions.
4. Explain the importance of recognizing driving limitations. Refer to community resources

GOUT-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

GOUT-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.

3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

GOUT-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

GRIEF - Grief/Bereavement

GRIEF-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to grief/bereavement.

STANDARDS:

1. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with the loss, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
2. Discuss that “normal” grieving/ bereavement may vary considerably among different cultural groups, and discuss the patient/family's social, cultural, and spiritual perception of grief.
3. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with grief.
4. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#).**
5. Refer to a mental health agency or provider, as needed.

GRIEF-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of unresolved grief/ bereavement.

STANDARDS:

1. Explain that grief/bereavement may develop into complications if it remains unexpressed, if it is masked by significant physical/behavioral symptoms, such as angry outbursts or somatizations, if it is exaggerated, and/or if grief from previous losses resurfaces.
2. Explain that complications of unexpressed grief may include depressed or anxious mood, disturbed emotions and behavior, and suicidal ideation.
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 further result in the development of Major Depressive Disorder (**refer to [“DEP - Depressive Disorders”](#)**), Posttraumatic Stress Disorder (**refer to [“PTSD - Posttraumatic Stress Disorder”](#)**), Substance-Related Disorders (**refer to [“AOD - Alcohol and Other Drugs”](#)**), and Somatization Disorders (**refer to [“SOMA - Somatoform Disorders”](#)**).

GRIEF-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in treating grief and co-morbid features.

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”](#).

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 their perception of grief and the grieving process.

STANDARDS:

1. Explain that “normal” grieving/bereavement may vary considerably among different cultural groups.
2. Discuss what influence that social, cultural, and spiritual traditions and variables have on the patient/family's perception of grief.
3. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
4. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

GRIEF-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in reducing the effects of grief/bereavement.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.

3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

GRIEF-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

GRIEF-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

GRIEF-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, based on the assessment of their social, cultural, and spiritual needs.
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

GRIEF-L LITERATURE

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

STANDARDS:

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

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

GRIEF-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of grief 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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

GRIEF-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in facilitating the grieving process.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in overcoming grief.
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.

GRIEF-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

GRIEF-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options for facilitating the grieving process.

STANDARDS:

1. Explain that individual psychotherapy is the treatment of choice for grief/ bereavement since the symptoms are an understandable reaction to a loss.
2. Explain that medication interventions are not usually prescribed for Grief/ Bereavement, although anti-depressants or anti-anxiety medications may be prescribed in conjunction to therapy for short periods to improve sleep, co-occurring disorders (e.g., Major Depression), or overall functioning.
3. Explain that therapists have different styles and orientations for treating grief/ bereavement, and that some styles may suit the patient better than others. Explain that therapy usually involves:
 - a. Developing or enhancing coping skills
 - b. Understanding how the stressor effected their lives
 - c. Developing alternate social or recreational activities
4. Explain that the treatment plan will be made by the patient and treatment team after reviewing available options. Explain that treatment for grief/ bereavement may vary according to the patient's life circumstances, severity of the condition, and available resources.
5. Discuss some activities that facilitate grieving.

6. Discuss how to integrate the social, cultural, or spiritual traditions of the patient and family into the healing process, based on the assessment of their needs and perceptions about grieving/bereavement.

GBS - Guillain-Barre Syndrome

GBS-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to Guillain-Barre Syndrome.

STANDARDS:

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

GBS-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to Guillain-Barre Syndrome.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with GBS as a life-altering illness that requires a change in lifestyle (**refer to ["GBS-LA Lifestyle Adaptations"](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with GBS, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to ["AOD - Alcohol and Other Drugs"](#)**.
6. Refer to a mental health agency or provider.

GBS-C COMPLICATIONS

OUTCOME: The patient/family will understand the possible complications of Guillain-Barre Syndrome.

STANDARDS:

1. Explain that involvement of respiratory muscles may potentiate hypoxia, atelectasis and pneumonia. Weakness of the laryngeal and glottic musculature may result in aspiration and tongue and retropharyngeal weakness may lead to airway obstruction.

2. 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.
3. Explain that another serious complication that can be treated is cardiac rhythm disturbances.
4. Explain that less serious complications that still require treatment may be abnormal blood pressure, urinary retention, gastrointestinal dysfunction, and fluid and electrolyte abnormalities.
5. 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-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in Guillain-Barre Syndrome.

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”](#).**

GBS-DP DISEASE PROCESS

OUTCOME: The patient/family will understand Guillain-Barre Syndrome.

STANDARDS:

1. Explain that the cause of Guillain-Barre Syndrome is unknown. Many persons with this syndrome experience a mild respiratory or gastrointestinal infection 1 to 3 weeks before the onset of neuritic symptoms. Infections and/or vaccinations may trigger an autoimmune response that damages the peripheral nerves. There is a higher incidence in men, Caucasians, young adults, and persons in their 50s.
2. Explain that GBS usually begins as bilateral paresthesia in the toes and fingertips, followed by lower extremity weakness that may spread to arms and trunk over a period of a few days. Paralysis may involve the muscles of respiration and cranial nerves leading to trouble breathing, chewing, swallowing, talking or opening the eyes.

3. Explain that muscle atrophy does not occur and the paralysis is usually temporary. Recovery is usually total, but convalescence may be lengthy and recovery may continue from 3 months to 2 years.
4. Explain that there is usually no pain, but tingling, burning, aching, or cramping may occur.
5. 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 understand and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
 - g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

GBS-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

GBS-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding Guillain-Barre Syndrome.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding GBS and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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 for Guillain-Barre Syndrome.

STANDARDS:

1. Discuss lifestyle adaptations specific to Guillain-Barre Syndrome. Teach the patient to check the feet daily for injuries. Minor injuries may go unnoticed because of sensory impairment.
2. Stress that over fatigue decreases accuracy of motor coordination should be avoided.
3. Discuss that the family may also require lifestyle adaptations to care for the patient.
4. Discuss ways to optimize quality of life. Explain that career counseling may be needed if recovery of neurologic function is prolonged.
5. Refer to community services, resources, or support groups, if available.

GBS-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

GBS-MNT MEDICAL NUTRITION THERAPY

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

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-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

GBS-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to Guillain-Barre Syndrome.

STANDARDS:

1. Discuss that GBS may cause paresthesias, gait unsteadiness, and the inability to walk.
2. Explain these neuropathies may increase risk of falls and precautions must be taken.

GBS-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in Guillain-Barre Syndrome.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in GBS.
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.

GBS-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test

2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

GBS-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

H

HPS - Hantavirus Pulmonary Syndrome

HPS-C COMPLICATIONS

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

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 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 understand 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 in the treatment of hantavirus.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

HPD-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient will understand the lifestyle changes necessary to promote and sustain healthy living.

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. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high-risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Review lifestyle aspects/changes and avoidance of high-risk situations where the hantavirus might lurk. (e.g., caution when cleaning, entering buildings that have been unused for long periods of time, awareness of the need to wear protective gloves, masks, etc. during cleaning).
4. 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.
5. Review the community resources available for help in achieving behavior changes.

HPS-L LITERATURE

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

STANDARDS:

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

HPS-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand 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; therefore, it is importance of keeping a clean and healthy home and yard to eliminate sources of nesting materials and sites. This might include:
 - a. The need to seal up the house to keep rodents out of the home.
 - b. The need to 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.
2. 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).
3. 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. If rodents or rodent droppings are suspected, use precautions, 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.
4. If contamination is suspected, 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.
5. Discuss that when going into 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-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

HPS-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results

- c. how results will impact or effect the treatment plan
- d. recommendations based on the test results

HPS-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available for HPS.

STANDARDS:

1. Explain that treatment is supportive and may include:
 - a. BiPAP or CPAP - refer to ["PL-EO Equipment"](#)
 - b. Nebulizer - refer to ["PL-EO Equipment"](#)
 - c. Oxygen
 - d. Intubation
 - e. Mechanical ventilation
 - f. Trachesostomy
2. Explain the criteria for discontinuing certain therapies, e.g., mechanical ventilation.
3. Explain that if the infected individuals are recognized early and admitted to intensive care, the chance for recovery is better.

LICE - Head Lice

LICE-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to lice.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with lice that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being infected with lice. Reassure the patient that head lice is common, especially among children attending childcare and school. Help the patient to deal with embarrassment.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the elimination of lice.
5. Refer to a mental health agency or provider.

LICE-C COMPLICATIONS

OUTCOME: The patient/family will understand complications relating to head lice.

STANDARDS:

1. Discuss common complications of head lice: The louse's saliva and feces may sensitize people to the louse's bites, thus exacerbating the irritation and itching.
2. Discuss that excessive scratching can cause a skin infection.

LICE-CM CASE MANAGEMENT

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

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, school personnel, 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”](#).

LICE-DP DISEASE PROCESS

OUTCOME: The patient/family will understand head lice.

STANDARDS:

1. Explain that sometimes people are not aware that they have head lice. Parents may only become aware of head lice on their children when notified by the child's school or by a public health nurse. Discuss the common signs and symptoms of head lice:
 - a. Tickling feeling in the hair
 - b. Frequent itching
 - c. Sores from scratching
 - d. Notification by the school
2. Discuss that the most important step in treating head lice is to treat the person and other family members with medicine to kill the lice:
 - a. An adult is called a louse and about the size of a small seed.
 - b. Nits (white eggs) that are attached to hair and cannot be shaken off. These may also be found on the neckline and behind the ears.
 - c. Red rash on the scalp and/or neck.
 - d. Itching and inflammation that may result in loss of sleep.
3. Discuss the transmission of head lice. Explain that lice are extremely contagious. Close contact or sharing personal belongings puts people at risk. Children ages 3-11 and their families get head lice most often. Personal hygiene has nothing to do with getting head lice. Children, who are around other children, can easily become infected with head lice:
 - a. May be acquired by direct head-to-head contact with an infested person's hair.
 - b. May be transferred with shared combs/hair brushes, hats, and other hair accessories.
 - c. May be transmitted through bedding or upholstered furniture.
4. Explain that head lice are dependent on blood and cannot survive for more than a day or so at room temperature without ready access to a person's blood.

LICE-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

LICE-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of head lice.

STANDARDS:

1. Explain the home management techniques, such as the importance of laundering clothing and linens in infected households:
 - a. Wash all bed linens and clothing in very hot water (130° Fahrenheit, or 54.4° Celsius) then put them in the hot cycle of the dryer for at least 20 minutes.
 - b. Dry-clean bed linens, clothing, stuffed animals, and plush toys that can't be washed, or put them in airtight bags for two weeks.
2. Instruct to vacuum carpets and any upholstered furniture (in the home or car) as this rids the environment of any hair that might contain the nits and lice.
3. Explain to not use fumigant sprays or fogs; they are not necessary to control head lice and can be toxic if inhaled or absorbed through the skin.
4. Instruct to soak hair-care items like combs, barrettes, hair ties or bands, hats, caps, and other head gear, headbands, and brushes in rubbing alcohol or medicated shampoo for one hour. In addition, they can be washed in hot water (or just throw them away).
5. Explain that personal hygiene is important but lice can quickly spread without a thorough cleaning of the home to rid the home of lice. To prevent reinfestation, stress the importance of not sharing personal items while at school or at home. Each family member should have their own personal grooming items.
6. Refer to community resources or support groups, as appropriate.

LICE-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to prevention and treatment of head lice.

STANDARDS:

1. Discuss the importance of personal hygiene to eliminate lice from the patient, family, and home.
2. Review the importance of bathing, paying special attention to hair and facial hair (beards, mustaches) and to pubic hair. Discuss hygiene as part of a positive self image.
3. Explain the importance of laundering clothing and linens in infected households:
 - a. Wash all bed linens and clothing in very hot water (130° Fahrenheit, or 54.4° Celsius) then put them in the hot cycle of the dryer for at least 20 minutes.
 - b. Dry-clean bed linens, clothing, stuffed animals, and plush toys that can't be washed, or put them in airtight bags for two weeks.
4. Instruct to vacuum carpets and any upholstered furniture (in the home or car).
5. Instruct to soak hair-care items like combs, barrettes, hair ties or bands, headbands, and brushes in rubbing alcohol or medicated shampoo for one hour. You can also wash them in hot water or just throw them away.

LICE-L LITERATURE

OUTCOME: The patient/family will receive literature about prevention and treatment of head lice.

STANDARDS:

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

LICE-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 used to rid the patient of lice.
2. Discuss the risks, benefits, and common or important side effects of the lice medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility to follow the directions to rid the patient and family of lice. Discuss any barriers to full participation.

LICE-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of acquiring head lice.

STANDARDS:

1. Explain that the following are steps that can be taken to help prevent and control the spread of head lice:
 - a. Avoid head-to-head (hair-to-hair) contact during play and other activities at home, school, and elsewhere (sports activities, playground, slumber parties).
 - b. Do not share clothing such as hats, scarves, coats, sports uniforms, hair ribbons, or barrettes.
 - c. Do not share combs, brushes, or towels. Disinfect combs and brushes used by an infested person by soaking them in hot water (at least 130°F) for 5-10 minutes.
 - d. Do not lie on beds, couches, pillows, carpets, or stuffed animals that have recently been in contact with an infested person.
 - e. Machine wash and dry clothing, bed linens, and other items that an infested person wore or used during the 2 days before treatment using the hot water (130°F) laundry cycle and the high heat drying cycle. Clothing and items that are not washable can be dry-cleaned OR sealed in a plastic bag and stored for 2 weeks.
 - f. Vacuum the floor and furniture, particularly where the infested person sat or lay.
 - g. Do not use fumigant sprays or fogs; they are not necessary to control head lice and can be toxic if inhaled or absorbed through the skin.
2. To prevent reinfestation, stress the important of not sharing personal items while at school or at home. The family members should have their own personal grooming items.

LICE-TX TREATMENT

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

STANDARDS:

1. Explain that the treatment for head lice is recommended for persons diagnosed with an active infestation. All household members and other close contacts should be checked; those persons with evidence of an active infestation should be treated. Some experts believe prophylactic treatment is prudent for persons who share the same bed with actively-infested individuals. All infested persons (household members and close contacts) and their bedmates should be treated at the same time.

2. Explain the treatment plan. Retreatment of head lice is often necessary. Discuss therapies that may be utilized including:
 - a. Use a medicated shampoo, cream, lotion, or home remedy to kill the lice.
 - b. Apply lice medicine, according to the instructions contained in the box or printed on the label. Pay special attention to instructions on the label or in the box regarding how long the medication should be left on the hair and how it should be washed out.
 - c. Have the infected person put on clean clothing after treatment.
 - d. If a few live lice are still found 8-12 hours after treatment, but are moving more slowly than before, do not retreat. The medicine may take longer to kill all the lice. Comb dead and any remaining live lice out of the hair using a fine-toothed nit comb.
 - e. If, after 8-12 hours of treatment, no dead lice are found and lice seem as active as before, the medicine may not be working. Do not retreat unless directed by the healthcare provider; a different lice medicine (pediculicide) may be necessary. If the healthcare provider recommends a different pediculicide, carefully follow the treatment instructions contained in the box or printed on the label.
 - f. Nit (head lice egg) combs, often found in lice medicine packages, should be used to comb nits and lice from the hair shaft. If necessary, manually remove the nits and live lice (place live lice on scotch tape and dispose). Many flea combs made for cats and dogs are also effective.
 - g. After each treatment, check the hair. Combing the hair with a nit comb to remove nits and lice every 2-3 days may decrease the chance of self-reinfestation. Continue to check for 2-3 weeks to be sure all lice and nits are gone.
 - h. Retreatment with most prescription and non-prescription (over-the-counter) drugs generally is recommended for day 9 in order to kill any surviving hatched lice before they produce new eggs. However, if using the prescription drug malathion, which kills the eggs, retreatment is recommended after 7-9 days ONLY if crawling bugs are found.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.

HA - Headaches

HA-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to this patient's type of headache.

STANDARDS:

1. Explain the normal anatomy and physiology of the area affected by this headache type.
2. Discuss the changes to anatomy and physiology as a result of headache.
3. Discuss the impact of these changes on the patient's health or well-being.

HA-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to headache.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with headaches as a life-altering illness that requires a change in lifestyle (**refer to [“HA-LA Lifestyle Adaptations](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with headaches, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#)**.
6. Refer to a mental health agency or provider.

HA-C COMPLICATIONS

OUTCOME: The patient/family will understand the possible consequences 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. Employment problems
- f. Relationship problems
- g. Cognitive difficulties
- h. Appetite change
- i. Sensitivity to light and noise
- j. Alteration in sleep patterns

HA-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the headache pain.

STANDARDS:

1. Explain that the patient is the primary source of information about the pain's location, quality, intensity, onset, precipitating or aggravating factors, frequency of headache pain, and the measures that bring relief.
2. Discuss the current knowledge of this patient's type of headache. Different types of headache include migraine, tension, sinus, or cluster.
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. Keeping a headache journal may be helpful in determining triggers. Some of these factors include:
- a. **Internal Factors:** hormonal changes, stress, change in sleep habits
 - b. **External Factors:** weather changes, alcohol, bright/flickering light, foods and beverages
 - c. **Physical Exertion**, such as exercise, physical work, or sexual intercourse

HA-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

HA-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process 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 the presence of:
 - a. headache restricts usual activities
 - b. headache lasting more than one day

- c. fever, stiff neck, nausea, or vomiting
- d. unusual drowsiness
- e. a recent head injury
- f. eye pain, blurred vision, or trouble seeing
- g. persistent headaches despite being seen by doctor
- h. difficulty speaking
- i. numbness or weakness of the arms or legs
- j. an increase in intensity or frequency over time
- k. acute onset of severe headache
- l. headaches that require the daily use of pain-reliever medications
- m. headaches experienced by very young children (preschool age)
- n. new onset of headaches in middle-aged people

HA-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding headaches.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding headaches and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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, avoidance of triggers, 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., foods and beverages, 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 type.
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 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

HA-MNT MEDICAL NUTRITION THERAPY

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

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 the 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 modified intake of milk products may be helpful.
5. Discuss the role of food and beverage journals in determining possible triggers.
6. 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 will 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.](#)**

HA-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management.](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

HA-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in headaches.

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, 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.

HA-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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.”](#)**
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 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 ADLs.

HPDP-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components of health and well being.

STANDARDS:

1. Discuss that wellness incorporates traditional medical, spiritual, mental/emotional, and cultural components.
2. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to ["AOD - Alcohol and Other Drugs"](#).**
3. Refer to a mental health agency or provider.

HPDP-CAR AUTOMOBILE SAFETY

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

STANDARDS:

1. Discuss the importance of always 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. Discuss current car seat laws as appropriate.
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.

PATIENT EDUCATION PROTOCOLS:**HEALTH PROMOTION, DISEASE PREVENTION**

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/elder 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 that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

HPDP-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 when becoming more fit.
5. Refer to community resources as appropriate.

HPDP-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

HPDP-HY HYGIENE

OUTCOME: The patient/family will recognize personal routine hygiene as an important part of wellness.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.

HPDP-IR INFORMATION AND REFERRAL

OUTCOME: The patient/family will have information on community or other resources appropriate to this patient.

STANDARDS:

1. Provide the patient/family with alternative or additional sources for care and services; for example, physical activity, car seat safety, nutrition, injury prevention, alcohol and drug prevention.
2. Provide the patient/family with assistance in securing alternative or additional resources as needed. Refer patient to services as needed.

HPDP-L LITERATURE

OUTCOME: The patient/family will receive literature about health promotion and disease prevention.

STANDARDS:

1. Provide the patient/family literature on health promotion and disease prevention.
2. Discuss the content of the literature.

HPDP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle changes 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/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.

PATIENT EDUCATION PROTOCOLS:**HEALTH PROMOTION, DISEASE PREVENTION**

4. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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. Identify and discuss any medication security issues.

HPDP-N NUTRITION

OUTCOME: The patient/family will understand health and nutrition.

STANDARDS:

1. Discuss the importance of eating a variety of foods and regular meals.
2. Review the relationship of calories to energy balance and body weight.
3. 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.
4. Emphasize the necessary component—WATER—in a healthy diet. Reduce the use of colas, coffee, and alcohol.
5. Review which community resources exist to assist with diet modification and weight control.
6. Stress the importance of being a smart shopper.

HPDP-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV

PATIENT EDUCATION PROTOCOLS:**HEALTH PROMOTION, DISEASE PREVENTION**

2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

HPDP-S SAFETY

OUTCOME: The patient/family will understand the role of safety and injury prevention in maintaining health.

STANDARDS:

1. Discuss the importance of vehicle safety. Some examples are:
 - a. Always 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 or elders 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. Some examples are:
 - a. Discuss poison prevention: e.g., proper storage and safe use of medicines, cleaners, auto products, paints.
 - b. Do not use ipecac syrup unless specifically told to do so by poison control or a physician.
 - c. Discuss common poisonous plants.
 - d. Provide the patient with the telephone number of poison control, Mr. Yuk or 1-800-222-1222.
3. Discuss the importance of fire safety and burn prevention. Some examples are:

- 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.
 - h. Discuss calling 911 for house fires and other emergencies.
4. Discuss the proper handling, storage, and disposal of hazardous items and materials. Some examples are:
 - 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. Some examples are:
 - a. Never swim alone.
 - b. When under the influence of alcohol or other drugs, never swim, boat, or use other recreational vehicles.
 - c. Never leave a child unattended in a bathtub, swimming pool, lake, river, or other water source.
 - d. Always close toilets, mop buckets, and other water containers to avoid toddler drowning.
 6. Discuss the importance of food and drinking water safety. Some examples are:
 - 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.

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/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.
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, 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.

HPDP-SX SEXUALITY

OUTCOME: The patient/family 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"](#)**), including abstinence and monogamy.
- 6. Review the community resources available for sexual counseling or examination.

HRA - Hearing Aids

HRA-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

HRA-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to using hearing aids.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of wearing hearing aids as a life-altering illness that requires a change in lifestyle (**refer to [“HRA-LA Lifestyle Adaptations](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in wearing hearing aids, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#)**.
6. Refer to a mental health agency or provider.

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, and open behind-the-ear BTE (OTE).

2. Explain the features available on hearing aids, e.g., telecoils, vents, shell materials, markings, removal handles, special circuitry, and directional microphone and remote control.
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. Emphasize 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 and process for obtaining follow-up appointments.
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. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of maintaining good personal hygiene to avoid ear canal infection.

3. 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 the importance of gradually increasing the daily time the hearing aid(s) are worn. The patient may notice some tenderness in the ear initially but this should resolve with continued wear. Any persistent soreness should be reported.
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.

HRA-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to hearing aid use.

STANDARDS:

1. Discuss the importance of having extra batteries available.
2. Discuss the dangers of driving, crossing streets, etc. when not wearing the hearing aid.
3. Recommend a medical alert identifier for hearing impairment/hearing aid use.

HRA-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in hearing aid use.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in hearing aid use.
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.

HL - Hearing Loss

HL-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand 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.
3. Discuss the impact of these changes on the patient's health or well-being.

HL-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to hearing loss.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with hearing loss as a life-altering illness that requires a change in lifestyle (**refer to [“HL-LA Lifestyle Adaptations](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with hearing loss, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#)**.
6. Refer to a mental health agency or provider.

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 the inability to hear 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 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, e.g., fluid in the middle ear, 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. Sensorineural hearing loss is permanent and cannot be medically or surgically corrected (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) the proper use and care of equipment.

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
 - g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.

3. 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.

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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding Hearing Loss.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding Hearing Loss and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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, firearms, and loud music, especially from ear buds.
3. Encourage the use of earplugs or other hearing protective devices. Explain the importance of using hearing protection for children who are too young to protect themselves.

HL-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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

HL-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to hearing loss.

STANDARDS:

1. Discuss the dangers of driving, crossing streets, etc. as applicable.
2. Recommend a medical alert identifier for hearing impairment/hearing aid use.

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-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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. Discuss treatment for reversible hearing loss.
3. Explain that a cochlear implant may help when a hearing aid does not give sufficient amplification.

HF - Heart Failure

HF-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family 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 many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is able to provide guidance at the time that decisions need to be made.
3. Explain that the Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences of care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.

HF-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

HF-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to heart failure.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with heart failure as a life-altering illness that requires a change in lifestyle (**refer to [“HF-LA Lifestyle Adaptations](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with heart failure, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#)**.
6. Refer to a mental health agency or provider.

HF-C COMPLICATIONS

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

STANDARDS:

1. Discuss common complications of heart failure, 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. Emphasize early medical intervention for signs and symptoms of complications.

HF-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.”](#)

HF-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

HF-DCHL DISCHARGE LITERATURE

OUTCOME: The patient/family will receive discharge literature specific to heart failure.

STANDARDS:

1. Provide patient/family with specific written patient information literature about heart failure.
2. Review the literature to include all the following:
 - a. Smoking cessation advice/counseling if the patient has smoked any time during the year prior to hospitalization.
 - b. All discharge medications.
 - c. Diet and fluid intake/limitations.
 - d. Activity level after discharge.
 - e. Follow-up with a provider after discharge.
 - f. Weight monitoring.
 - g. What to do if heart failure symptoms worsen.

HF-DP DISEASE PROCESS

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

STANDARDS:

1. Explain that heart failure 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 heart failure as it relates to the patient's condition, e.g., previous MI, long-standing hypertension.
3. Review signs and symptoms of heart failure, e.g., swelling, fatigue, shortness of breath, weight gain.

HF-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
 - g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

HF-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. Explain the importance of not exercising on days when weight is increased or illness is present.
2. Discuss the benefits of any exercise, such as improvement in well being, stress and depression 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.

HF-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

HF-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding heart failure.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding heart failure and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

HF-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of 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, monitor daily weight and blood pressure, follow prescribed diet, 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 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. Review how to balance activity and rest.

HF-L LITERATURE

OUTCOME: The patient/family will receive literature about heart failure.

STANDARDS:

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

HF-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adjustments necessary to maintain control of 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 the quality of life. (Attain or maintain a healthy weight, monitor daily weight and blood pressure, follow prescribed diet, cook at home more instead of eating out, 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. Review how to balance activity and rest.

HF-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

HF-MNT MEDICAL NUTRITION THERAPY

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

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.

HF-N NUTRITION

OUTCOME: The patient/family will develop a plan to control heart failure through weight control and reduced sodium intake.

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 dietitian or other local resources as available.
5. Assist in developing appropriate diet plan to achieve optimal weight and sodium control.

HF-P PREVENTION

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

STANDARDS:

1. Discuss causative factors of health failure such as uncontrolled hypertension, pulmonary hypertension, or viral illnesses.
2. Explain that limiting sodium intake, maintaining a healthy body weight and controlling blood pressure can reduce the risks of developing heart failure.

HF-PRO PROCEDURE

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 of 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 for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site

- d. time out for patient identification and procedure review
- e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

HF-SHS SECOND-HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Explain that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, and many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia, SIDS, and lung cancer.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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.

HF-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in heart failure.

STANDARDS:

1. Explain that uncontrolled stress can increase the severity of heart failure.
2. Explain that uncontrolled stress can interfere with the treatment of 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 heart failure.
4. Explain that effective stress management may help reduce the severity of 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 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
 - 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.

HF-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

HF-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

HF-TO TOBACCO

OUTCOME: The patient/family will understand the dangers of smoking.

STANDARDS:

1. Explain the increased risk of complications and chronic lung disease in the patient with heart failure 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](#).**

HF-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

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 that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.
3. Explain the potential effects of saunas, sweathouses, and sun dances may have on the hydration of the body.

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 that heatstroke is an emergency.
2. Discuss signs and symptoms of heatstroke with the patient:
 - a. Headache

- b. Vertigo
 - c. Fatigue
 - d. Decreased sweating
 - e. Skin warm to touch
 - f. Flushing
 - g. Increased heart rate
 - h. Increased respiratory rate
3. Discuss the pathophysiology of heat stroke: inadequacy or failure of the heat loss mechanism.
 4. Explain factors that may predispose to heatstroke:
 - a. Disease status or conditions, such as diabetes, anhidrosis, or previous episodes of heat stroke.
 - b. Environmental conditions such as high humidity, extremely high temperatures
 - c. Clothing that is tight or made of spandex or rubber

HEAT-EX EXERCISE

OUTCOME: The patient/family will understand how heatstroke can be influenced by exercise.

STANDARDS:

1. Discuss how exercising in a warm environment, excessive exercising and prolonged exercise and exertion can lead to heat stroke.
2. Discuss the importance of frequent hydration and rest when exercising in a warm environment.
3. Discuss medical clearance issues for physical activity.
4. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
5. Discuss obstacles to a personal physical activity plan and solutions to those obstacles.
6. Discuss the appropriate frequency, intensity, time, and type of activity.

HEAT-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of heatstroke and to determine if there is permanent or ongoing damage.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

HEAT-L LITERATURE

OUTCOME: The patient/family will receive literature about heatstroke and important preventive measures.

STANDARDS:

1. Provide the 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/family will understand the specific nutritional intervention(s) needed for treatment or management of heatstroke.

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. Heatstroke usually happens in the summer months.
2. Explain that avoiding extremely hot/humid environments, inadequately ventilated spaces, inadequate fluid intake and heavy clothing in warm conditions can prevent heat stroke. Take frequent showers, wear light weight clothing, and avoid direct sunlight.
3. Explain when heat exposure cannot be avoided: reduce or eliminate strenuous activities, stay adequately hydrated.
4. Discuss that generous amounts of water may be required to prevent dehydration and heat stroke. For example, adults should consume one liter per hour. Explain that water is the beverage that best hydrates the body.

5. Discuss 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-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to heat stroke.

STANDARDS:

1. Discuss avoidance of hot/humid environments, inadequately ventilated spaces, inadequate fluid intake and heavy clothing in warm conditions.
2. Discuss 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 climate, certain medications, and prolonged outdoor activities.

HEAT-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

HEAT-TX TREATMENT

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

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.

HEM - Hemorrhoids

HEM-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of the anus and anal canal.
2. Discuss changes to anatomy and physiology as a result of hemorrhoids that have become swollen and inflamed.
3. Discuss the impact of these changes on the patient's health or well-being.

HEM-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of hemorrhoids and the symptoms associated with complications.

STANDARDS:

1. Discuss common complications of hemorrhoids including
 - a. anemia: due to chronic blood loss
 - b. strangulation: blood supply to an internal hemorrhoid is cut off
 - c. thrombosis: a blood clot forms in the hemorrhoid
2. Describe the signs/symptoms of common complications of hemorrhoids:
 - a. extreme pain or swelling
 - b. heavy rectal bleeding
 - c. fatigue and weakness

HEM-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

HEM-DP DISEASE PROCESS

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

STANDARDS:

1. Explain hemorrhoids are swollen and inflamed veins under the skin around the anus (external) or inside the lower rectum (internal) caused by pressure on the veins.
2. Discuss factors that can cause increased vein pressure in the rectal and anal areas:
 - a. straining during bowel movements
 - b. chronic diarrhea or constipation
 - c. obesity
 - d. pregnancy
 - e. sitting or standing for prolonged periods
 - f. injury to the anus
 - g. blood on toilet tissue or in the toilet after a bowel movement
 - h. a lump near the anus, which may be sensitive or painful
 - i. leakage of feces

HEM-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in the prevention of hemorrhoids and hemorrhoid outbreaks.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity:
 - a. exercise for hemorrhoid prevention and hemorrhoid outbreaks include toning, stretching and walking exercises; these activities increase blood flow, enhance muscle tone and stimulate bowel function (i.e., walking, running, swimming, yoga, daily stretching, moderate aerobics, kegel exercises)
 - b. when hemorrhoids are present, avoid activities that cause pain or discomfort or place extra pressure on sensitive areas (i.e., horseback riding, cycling, rowing, weightlifting)
5. Refer to community resources as appropriate.

HEM-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

HEM-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of hemorrhoids.

STANDARDS:

1. Explain the home management techniques to relieve symptoms of hemorrhoids:
 - c. warm bath or sitz bath to relieve discomfort and promote healing
 - d. ice packs or cold compresses to relieve swelling
 - e. wear cotton underwear to prevent moisture buildup
 - f. apply over-the-counter treatments to protect hemorrhoids and reduce anal symptoms such as itching and discomfort
2. Discuss the implementation of hygiene and infection control measures.:
 - a. bathe or shower daily to keep area clean; gently pat dry the area after bathing
 - b. use scent-free moisture towelettes or wet toilet paper to clean area after bowel movement

HEM-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and

substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.

3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

HEM-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to hemorrhoids.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

HEM-L LITERATURE

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

STANDARDS:

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

HEM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations in the management or prevention of hemorrhoids.

STANDARDS:

1. Discuss lifestyle adaptations specific to hemorrhoids including:
 - a. implement recommended dietary change (foods high in fiber)
 - b. increase water intake
 - c. employ bowel habit modification; do not put off having a bowel movement
 - d. exercise regularly; avoid sedentary life style
 - e. if job requires prolong sitting, stand and walk around once every hour
 - f. if job required prolonged standing, schedule a break to sit and relax
 - g. avoid excessive heavy lifting; use proper lifting techniques
 - h. reduce stress
 - i. take off excess weight
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

HEM-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

HEM-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for hemorrhoids.

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.

HEM-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to hemorrhoids.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Review the need to eat high-fiber foods (i.e., fruits, vegetables, whole grains) to maintain regular, soft bowel movements.
3. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
4. Discuss the importance of regular meals and adequate fluid intake.
5. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
6. Refer to registered dietitian for MNT or other local resources as appropriate.

HEM-P PREVENTION

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

STANDARDS:

1. Explain that the best way to prevent hemorrhoids is to keep stools soft so they pass easily.
2. Discuss the diet and lifestyle choices that may help prevent hemorrhoids:

- a. eat high-fiber foods
- b. drink plenty of fluids
- c. exercise regularly
- d. lose excess weight
- e. have regular bowel movements and don't strain
- f. do not postpone having a bowel movement
- g. avoid long periods of sitting or standing
- h. avoid excessive heavy lifting; use proper lifting techniques
- i. reduce stress

HEM-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

HEM-PRO PROCEDURE

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 the proposed procedure as well as the alternatives and the risk of non-treatment (i.e., rubber band ligation hemorrhoidectomy).
2. Explain the process and what is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification

- c. marking the surgical site
- d. time out for patient identification and procedure review
- e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

HEM-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect on health and well being and may make existing hemorrhoid symptoms worsen.
2. Explain the role of effective stress management in hemorrhoid treatment.
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.

HEM-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate) (i.e., fecal occult blood test, digital rectal exam test, anoscope exam, colonoscopy):
 - a. method of testing

- b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

HEM-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

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-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to hepatitis.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with hepatitis as a life-altering illness that requires a change in lifestyle (**refer to ["HEP-LA Lifestyle Adaptations"](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with hepatitis, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to ["AOD - Alcohol and Other Drugs"](#)**.
6. Refer to a mental health agency or provider.

HEP-C COMPLICATIONS

OUTCOME: The patient/family will understand the long term consequences of viral infections with HAV, HBV, and HCV.

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 that complication may include: cirrhosis (scarring of the liver), or liver failure, or liver cancer.

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”](#).**

HEP-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 health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to lifestyles.
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.

HEP-DPA DISEASE PROCESS HEPATITIS A

OUTCOME: The patient/family or caregiver will understand that hepatitis A is an inflammation of the liver caused by hepatitis A virus (HAV).

STANDARDS:

1. Explain that the HAV infection is most commonly spread through food when the food preparer is infected with hepatitis A.

2. Discuss that the patient's symptoms may include fever, nausea, vomiting, jaundice, diarrhea, fatigue, abdominal pain, dark urine, and appetite loss. It will usually last for about 3 weeks.
3. Emphasize that other symptoms such as respiratory symptoms, rash, and joint pain may also develop.
4. Explain 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 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 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.

STANDARDS:

1. Explain that Hepatitis C is an infection transmitted primarily by blood. Explain that most 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 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 patients 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 will understand the importance of follow-up the treatment of hepatitis.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

HEP-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding Hepatitis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding Hepatitis and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

HEP-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of hepatitis.

STANDARDS:

1. Emphasize the importance of avoiding alcohol, acetaminophen, aspirin, and herbal supplements, unless otherwise directed by the provider.
2. Discuss the implementation of hygiene and infection control measures.

3. Refer to community resources, hospice, or support groups, as appropriate.

HEP-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain how to obtain Hep A and Hep B vaccines as appropriate.
2. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
3. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high-risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
4. 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
5. Review the community resources available for help in achieving behavior changes.

HEP-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to hepatitis.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.

4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

HEP-L LITERATURE

OUTCOME: The patient/family or caregiver will receive literature about hepatitis, vaccine information or preventive measures.

STANDARDS:

1. Provide the patient/family with literature 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
2. Discuss that persons with Hep B or Hep C should not donate blood or organs.
3. Discuss that family may also require lifestyle adaptations to care for the patient.
4. Discuss ways to optimize quality of life.
5. Refer to community services, resources, or support groups, as available.

HEP-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

HEP-MNT MEDICAL NUTRITION THERAPY

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

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 dietitian or other local resources as indicated.

HEP-P PREVENTION

OUTCOME: The patient/family will understand the modes of transmission, ways to prevent acquiring the virus.

STANDARDS:

1. Explain that hepatitis A is generally spread by fecal - oral route therefore, careful hand washing is paramount. 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 and that there is no vaccine for prevention of hepatitis C; the use of immunoglobulin against Hep A and B for post exposure prophylaxis.
3. 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.
4. Discuss that Hepatitis B can be spread by sexual transmission. Adequate protective barriers are important.
5. Discuss that persons with hepatitis should not donate plasma, blood, sperm, or organs because this may spread the virus to others.

HEP-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss that Hep B and Hep C can be transmitted from the mother to the child during pregnancy and child birth but not through breastfeeding.
2. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations

- h. limit exposure to occupational hazards
- i. screening and treatment for STIs, including HIV
3. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
4. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
5. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
6. Refer for medical and psychosocial support services for any risk factor identified.

HEP-PRO PROCEDURE

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 of the proposed procedure as well as the alternatives and the risk of non-treatment.
2. Discuss the process and what is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

HEP-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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, including transplant for liver failure.
3. Emphasize the importance of rest and proper nutrition in recovery from hepatitis.
4. Discuss ways to protect the liver from further harm:
 - a. avoid alcoholic beverages
 - b. inform your provider of all the medications, even over the counter and herbal medication
 - c. have regular doctor visits
 - d. get vaccinated against Hepatitis A and B
5. Discuss the need for screening for liver cancer with blood test and ultrasound, once or twice a year.

IV - Home IV Therapy

IV-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to this specific IV site.

STANDARDS:

1. Explain the normal anatomy and physiology of the venous system where this IV has been placed.
2. Discuss changes to anatomy and physiology as a result of this IV site.
3. Discuss the impact of these changes on the patient's health or well-being.

IV-C COMPLICATIONS

OUTCOME: The patient/family will understand

STANDARDS:

1. Discuss common complications of home IV therapy for this type IV, e.g., infection, phlebitis, air embolus.
2. Describe the signs/symptoms of common complications of home IV therapy and the importance of seeking medical attention immediately.

IV-CM CASE MANAGEMENT

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

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"](#).**

IV-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

IV-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

IV-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of this specific IV site.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

IV-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of this specific IV site.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

IV-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

IV-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to this specific IV site.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.

- a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and this specific IV site management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
 3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
 4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
 5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

IV-L LITERATURE

OUTCOME: The patient/family will receive literature about this specific IV site.

STANDARDS:

1. Provide the patient/family with literature on this specific IV site.
2. Discuss the content of the literature.

IV-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for this specific IV site.

STANDARDS:

1. Discuss lifestyle adaptations specific to this specific IV site.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

IV-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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 specific cautions related to the administration of this medication intravenously at home.

IV-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) related to this specific IV therapy.

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.

IV-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

IV-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.
6. Discuss the procedures for home care, including:
 - a. infusion rate calculation and using a drip regulator device
 - b. flushing the IV device
 - c. appropriate tubing changes
 - d. inspecting the solutions for infusion to make sure they are correct and not cloudy or discolored

IV-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to this specific IV site.

STANDARDS:

1. Explain the importance of meticulous cleanliness of the hands, skin around, dressings, etc. in relation to using the IV catheter, tubing or containers.
2. Discuss the importance of removing all air from the IV tubing before attaching to the IV and removing air from syringes before injecting.
3. Discuss arranging IV tubing to prevent disconnection and/or accidental dislodgement of the IV catheter or tripping over the tubing.

IV-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in home IV therapy.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in dealing with home IV therapy.
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.

IV-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

IV-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

IV-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

IV-WC WOUND CARE

OUTCOME: The patient/family will understand proper wound care and infection control measures for this specific IV site.

STANDARDS:

1. Explain the reasons to care appropriately for the specific IV site, e.g., decreased infection rate.
2. Emphasize the importance of hand hygiene before and after caring for the specific IV site and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's IV site including aseptic technique and the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary IV site care techniques.
4. Detail the supplies necessary for care of this IV site (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness at the site, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's IV site.

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 appropriate services to assist the patient in making a living will, e.g., Social Services, Clergy, Lawyer.
4. Refer to ["ADV - Advance Directives"](#).

HIV-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to HIV.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with HIV as a life-altering illness that requires a change in lifestyle (**refer to ["HIV-LA Lifestyle Adaptations"](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with HIV, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to ["AOD - Alcohol and Other Drugs"](#)**.
6. Refer to a mental health agency or provider.

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 adverse events related to the 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
 - f. depression, anxiety, or other mental health issues
2. Discuss common or significant complications that may be prevented by full participation with the treatment regimen including how treatment adherence may prolong healthy years of life.
3. Discuss common or significant complications or adverse events 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 mental, 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"](#).

HIV-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that if the overall wellness of the patient involves both traditional medicines/treatments and western medicines, it should be reviewed with the healthcare provider to determine any potential effects of combined treatment.
3. Discuss role and importance of support infrastructure (family, friends, partners, traditionalists) 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

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 fetus/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 is non-selective and a risk to all.
3. Explain that HIV is a virus that attacks the immune system resulting in increased susceptibility to infections and cancers. There is no current vaccine to prevent its occurrence.
4. Explain the difference between HIV infection and AIDS. Explain that it is currently believed that all HIV infections will progress to AIDS. Some of the effects of AIDS may include acquiring unusual or more frequent infections that are especially difficult to treat.
5. Explain that early treatment and strict participation may slow the progression from HIV infection to AIDS and help decrease transmission potential of the virus.

HIV-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment. Emphasize the importance of proper use of 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, assistance from HIV case managers, and the patient's healthcare team.
2. Discuss the procedure and process for obtaining follow-up appointments.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family in partnership with the healthcare team.
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding HIV.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding HIV and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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 relief of any symptoms. Explain that communication of these symptoms to a provider is critical.
2. Discuss the use of alternative therapies or complimentary medicines 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-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, and nutrition) and avoidance of high-risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners, etc.) and their effects on HIV and AIDS. Discuss the benefits of a healthy lifestyle.
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.

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. Offer assistance or referral to address this high-risk behavior of IV drug use.
5. Discuss the importance and implications of preventing unprotected sexual activity:
 - a. Use a new latex or polyurethane condom every time during 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 sexual devices are used, don't share them.
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 the 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 the sexual partner(s) about having HIV
 - c. if the partner is pregnant, tell her about having 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 the patient is 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 negative effects of smoking, use of illegal drugs, or alcohol as these further weaken the 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

HIV-MNT MEDICAL NUTRITION THERAPY

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

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 dietitian 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. unprotected 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, increase risky behavior, 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-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.

4. Discuss the importance of advanced family planning (reproductive planning).
Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

HIV-PN PRENATAL (REFER TO PN-HIV)

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 reactions to stress
 - b. recognizing and accepting personal limits
 - c. talking with trustworthy people about 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 as much as possible about HIV/AIDS
 - b. be proactive and take an active role in the treatment
 - c. maintain a strong support system
 - d. take time to make important decisions concerning the future
 - e. come to terms with the 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 test(s) that have been ordered (explain as appropriate):
 - a. method of testing (emphasize the importance of using only approved test kits for HIV)
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making

- f. how to obtain the results of the test
2. Explain that identification of all partners is necessary to facilitate the testing of those persons and limit further spread of the infection.
3. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results
 - e. the results will remain confidential

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 continuous 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 Highly Active Antiretroviral Therapy (HAART). The aim of HAART is to reduce the amount of virus in the blood to very low levels, although this doesn't mean the virus is gone.
4. Discuss the process for developing a comprehensive treatment plan that includes identifying the appropriate resources to support a comprehensive treatment plan, e.g., health and risk assessment, referral to mental health for associated depression or mental illness, common lab tests, disease staging, prophylaxis therapy, immunizations, social and insurance needs, plus follow up.
5. 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.
3. Explain that hyperlipidemia/dyslipidemia puts patients at higher risk of 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”](#).

LIP-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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 physical activity in hyperlipidemia/dyslipidemia.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, and cardiovascular health.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.

4. Discuss the appropriate frequency, intensity, time, and type of activity.
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. Emphasize the importance of follow-up care, including labwork.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of hyperlipidemia/dyslipidemia.

STANDARDS:

1. Explain the home management techniques for heart-health cooking.
2. Refer to community resources, hospice, or support groups, as appropriate.

LIP-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.

- c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

LIP-L LITERATURE

OUTCOME: The patient/family will receive literature about hyperlipidemia/dyslipidemia.

STANDARDS:

1. Provide the 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 for hyperlipidemia/dyslipidemia.

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. Review the nationally accepted, current lipid reduction goals and assist the patient to establish a personal plan for lipid control.

LIP-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.

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.

LIP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will 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 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, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s), e.g., fasting
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

LIP-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

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-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

HTN-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to hypertension.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with hypertension as a life-altering illness that requires a change in lifestyle (**refer to [“HTN-LA Lifestyle Adaptations](#)”).**
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with hypertension, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).”**
6. Refer to a mental health agency or provider.

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 high blood pressure can reduce blood flow and oxygen to the heart which can cause chest pain and heart attacks.

3. Explain that blindness may result from injured blood vessels in the eye.
4. Explain that high blood pressure may cause blood vessels to the brain to more easily burst or become clogged by blood clots, resulting in a stroke.
5. Explain that circulatory complications eventually impair the ability of the kidneys to filter out toxins.
6. Explain that high blood pressure can affect the circulation to other organ systems and might cause damage, such as PAD or ED.

HTN-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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. Encourage regular blood pressure and weight checks.

HTN-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding hypertension.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding hypertension and dealing with issues.
2. Provide the help line phone number or Internet address (URL):
 - a. http://www.nlm.nih.gov/health/dci/Diseases/Hbp/HBP_WhatIs.html
 - b. http://www.nlm.nih.gov/health/dci/Diseases/dash/dash_what.html

HTN-L 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/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](#).

HTN-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes

- d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

HTN-SCR SCREENING

OUTCOME: The patient/family will understand the proposed screening including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed screening, e.g., guaiac, blood pressure, hearing, vision, development, mental health.
2. Explain the process and what to expect after the screening.
3. Emphasize the importance of follow-up care.

HTN-SHS SECOND-HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Explain that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, and many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia, SIDS, and lung cancer.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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.

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, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)

- e. how the results will be used for future medical decision-making
- f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

HTN-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

HTN-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

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 hyperthyroidism.
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-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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 the hypersecretory state of the thyroid gland (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 non-tender

HTH-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding Hyperthyroidism.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding Hyperthyroidism and dealing with issues.
2. Provide the help line phone number or Internet address (URL), such as <http://endocrine.niddk.nih.gov/pubs/Hyperthyroidism/>

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/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 dietitian for MNT as appropriate.

HTH-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

HTH-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed

- c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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](#).**
4. Emphasize to seek early medical intervention.

HPTH-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

HPTH-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of hypothermia.

STANDARDS:

1. Explain that a drop in the body's core temperature to 95°F or below is the definition of hypothermia and 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;

the extremities are generally cooler than the trunk and the body core is generally warmer than the skin surface.

3. Discuss that hypothermia usually comes on gradually and people aren't aware they need medical attention. 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
4. Briefly describe hypothermia causes vasoconstriction, alterations in microcirculation, coagulation, and ischemic tissue damage.
5. 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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 patient/family will receive literature about hypothermia and important preventative measures.

STANDARDS:

1. Provide the patient/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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

HPTH-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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 dietitian 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.”](#)**
- 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(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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 understand anatomy and physiology as it relates to 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 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 thyroid supplement.
4. Review the symptoms of hypothyroidism, which include:
 - 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 hypothyroidism.

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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding Hypothyroidism.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding Hypothyroidism and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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/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 excessive use of soy proteins and the following raw vegetables may increase the risk of developing a goiter and make medications less effective: cabbage, Brussels sprouts, kale, cauliflower, asparagus, broccoli, lettuce, peas, spinach, turnip greens, and watercress. Explain that cooking the vegetables reduces this risk.
4. Encourage the use of iodized salt if indicated, adequate fluid intake, and high fiber.
5. Refer to a registered dietitian for MNT.

LTH-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.

3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

LTH-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

I**IM - Immunizations****IM-C COMPLICATIONS**

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

STANDARDS:

1. Discuss common complications of the specific immunization.
2. Describe the signs/symptoms of common complications of this specific immunization.
3. Explain that after live virus vaccine administration, the patient should avoid contact with immunocompromised individuals.
4. Explain that scientific studies and reviews have found no relationship between vaccines and autism.

IM-DEF DEFICIENCY

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

STANDARDS:

1. Identify reasons for deficiency and provide education as indicated.
2. Explain that deficiency of immunization(s) may cause serious health problems.
3. Discuss diseases that have been eradicated due to immunizations.
4. Discuss the patient's particular immunization deficiency.
5. Review complications that could occur if infection develops.

IM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up 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. Explain that there is a delay before immunity develops.
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 and what to do if serious side effects are observed. Explain that the use of antipyretics may diminish the immune system's response to the vaccine.
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 about immunizations.

STANDARDS:

1. Provide the patient/family with literature on the different types of immunizations and schedule for immunizations. 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/vaccines/pubs/vis/default.htm>
2. Discuss the content of the literature.

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-C COMPLICATIONS

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

STANDARDS:

1. Discuss common complications of impetigo.
2. Describe the signs/symptoms of common complications of 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 is a skin infection that may be caused by the streptococcus or staphylococcus germs can spread from one place to another on the body.
2. 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.
3. Explain that itching is common and scratching may spread the infection.
4. 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/family will understand the importance of follow-up in the treatment of impetigo.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to impetigo.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

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. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
5. 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. Explain that certain infections can be dependent upon hygiene, social and/or environmental conditions. **Refer to ["HPDP-HY Hygiene"](#).**
2. Instruct the patient/family in hygiene to prevent impetigo.
 - a. Wash with soap and water every day.
 - b. Wash hands whenever they are dirty.
 - c. Keep the fingernails cut and clean.
 - d. Take care of cuts, scratches, and scrapes. Instruct to wash with soap and water.
 - e. Avoid sharing clothes, towels, toys, dishes, etc. with a person who has impetigo.
 - f. Wash all toys of the infected person 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.

IMP-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

IMPLS - Impulse Control Disorders

IMPLS-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications to Impulse Control Disorders.

STANDARDS:

1. Explain that Intermittent Explosive Disorder is most often associated with adverse social consequences, such as loss of a job, school suspension, financial problems, difficulty in interpersonal relationships, divorce, car accidents, injuries, and hospitalizations.
2. Explain that Impulse Control Disorders are usually associated with legal consequences because the individuals are either indifferent to arrest or do not fully take into account the chances of apprehension.
3. Explain that aggressive behavior noted in Intermittent Explosive Disorder may require the use of restraints and seclusion (**refer to [“RST - Restraints and Seclusion”](#)**) in some settings to protect themselves and others, and to prevent further complications.
4. Explain that Impulse Control problems may sometimes be a complication itself of other medical conditions, such as Parkinson’s Disease.
5. Explain that Impulse Control Disorders may also be associated with substance abuse (**refer to [“AOD - Alcohol and Other Drugs”](#)**) and suicide (**refer to [“SI - Suicidal Ideation and Gestures”](#)**), if left untreated.

IMPLS-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in the treatment of Impulse Control Disorder.

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”](#).**

IMPLS-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

IMPLS-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of Impulse Control Disorders.

STANDARDS:

1. Discuss the essential feature of Impulse Control Disorders as the failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others.
2. Explain the symptoms of the specific Impulse Control Disorder:
 - a. **Intermittent Explosive Disorder** is characterized by discrete episodes of failure to resist aggressive impulses resulting in serious assaults or destruction of property.
 - b. **Kleptomania** is characterized by the recurrent failure to resist impulses to steal objects not needed for personal use or monetary value, nor committed to express anger or vengeance.
 - c. **Pyromania** is characterized by a pattern of fire setting purely for pleasure or gratification.
 - d. **Pathological Gambling** is maladaptive gambling behavior, which resembles addictive patterns (**refer to [“AOD-DP Disease Process”](#)**).
 - e. **Trichotillomania** is characterized by recurrent pulling out of one's hair for pleasure, gratification, or relief of tension, which results in noticeable hair loss.
 - f. **Impulse Disorder Not Otherwise Specified (NOS)** includes any impulse control disorder that does not meet the criteria for any specific disorder.
3. Explain that for most of the Impulse Control Disorders the individual feels an increasing sense of tension or arousal before committing the act, and feels pleasure, gratification, or relief during and/ or after the act.
4. Explain that following the impulsive act, afflicted individuals usually feel a loss of control over the acts, and there may or may not be regret, self-reproach, or guilt.
5. Discuss the differential diagnosis.

IMPLS-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in releasing stress and tension appropriately.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

IMPLS-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

IMPLS-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding impulse control disorders.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding support for and treatment of impulse control disorders.
2. Provide the help line phone number or Internet address (URL).

IMPLS-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

IMPLS-L LITERATURE

OUTCOME: The patient/family will receive literature about the specific Impulse Control Disorder under consideration.

STANDARDS:

1. Provide the patient/family with literature on the specific Impulse Control Disorder under consideration.
2. Discuss the content of the literature.

IMPLS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary to reduce or eliminate the symptoms of Impulse Control Disorders.

STANDARDS:

1. Discuss lifestyle adaptations specific to reduce and cope with stress.
2. Discuss that family may also require lifestyle adaptations to cope with these difficulties.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

IMPLS-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

IMPLS-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for Impulse Control Disorders.

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.

IMPLS-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to Impulse Control Disorder.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

IMPLS-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of Impulse Control Disorders.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

IMPLS-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to Impulse Control Disorders, and the risk of suicide, homicide, or injury.

STANDARDS:

1. Discuss the consequences of dangerous acts, such as assault and fire setting.
2. Discuss/review the safety plan with the patient and family, including the no-harm contract and emergency procedures should the condition exacerbate, or should, agitation, tension, or suicidal/homicidal ideation arise

3. Review the local resources and phone numbers, including the police, who may be utilized during a crisis, and may assist in transportation and safety compliance.

IMPLS-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in coping with Impulse Control Disorders.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in reducing tension appropriately.
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.

IMPLS-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.

3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

IMPLS-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options that may be used to treat Impulse Control Disorders.

STANDARDS:

1. Explain that a combination of psychotherapy and medication interventions usually have better results than therapy or medication alone.
2. Explain that therapists have different styles and orientations for treating Impulse Control Disorders, and that some styles may suit the patient better than others, which includes:
 - a. Cognitive Behavior Therapy
 - b. Psychodynamic Psychotherapy
 - c. Group Therapy
3. Explain some of the common medications that have been shown to be effective in reducing impulsive behavior and the associated effects of stress and tension. **Refer to [“IMPLS-M Medications”](#).**
4. Explain that the treatment plan will be made by the patient/family and treatment team after reviewing available options. Explain that treatment for Impulse Control Disorders may vary according to the patient's life circumstances, severity of the condition, and available resources, which may include referrals to inpatient psychiatric hospitals.

FLU - Influenza

FLU-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to the respiratory system and influenza.

STANDARDS:

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

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. Complications of flu can lead to death.
2. 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.
3. Discuss the importance of not giving aspirin or products containing aspirin to children (under 16 years of age) with the flu because it may induce a potentially fatal complication of the flu called Reye's Syndrome.

FLU-CM CASE MANAGEMENT

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

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"](#).

FLU-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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 a 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.
5. In the case of novel flu, explain that influenza is a virus that has subtypes and strains that can affect humans, birds, pigs, or other animals. Sometimes these viruses change to allow person-to-person transmission.
 - a. Discuss characteristics of the novel influenza virus as it relates to:
 - i. Transformational change of the virus that alters its characteristics.
 - ii. Special recommendations for prevention of infection with and or further spread of the novel influenza virus.
 - iii. Special recommendations, if any, regarding contact with animals. Consuming cooked animals does not cause the flu.
 - iv. Severity of the illness caused by the novel influenza virus.
 - b. Discuss with the patient/family the unique risks associated with novel flu.

- c. Discuss any unique testing or treatment options for novel flu.
- d. Refer to current CDC recommendations for specific information.

FLU-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of influenza.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

FLU-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.

- b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

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. 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.
5. 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.
6. 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/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 small frequent meals or sips of fluid may be better tolerated than larger meals.
3. 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.
 - b. Small frequent intake of fluids will be better tolerated.
 - c. 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 to prevent the flu.

STANDARDS:

1. Explain that the most important action to take is to get an annual flu vaccine. The vaccine may make it milder.
2. Explain that avoiding contact with sick people will help reduce getting the flu. If you have the flu stay home from work or school or large gathering to limit contact.

FLU-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

FLU-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

FLU-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

INJ - Injuries

INJ-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of the injured organ or body part.
2. Discuss the changes to anatomy and physiology as a result of this specific injury.
3. Discuss the impact of these changes on the patient's health or well-being.

INJ-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to the specific injury.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with the specific injury as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with the specific injury, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).**
6. Refer to a mental health agency or provider.

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/family will understand the importance of follow-up for injuries.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.

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 on the specific injury.
2. Discuss the content of the literature.

INJ-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

INJ-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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 the 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.”](#)

INJ-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 and the patient; and may be multifaceted. Refer to [“PM - Pain Management.”](#)
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.
5. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.

INJ-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

INJ-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 participation with treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

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. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

J

JRA - Juvenile Rheumatoid Arthritis

JRA-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of joints and other parts of the body.
2. Discuss the changes to anatomy and physiology as a result of JRA. Discuss JRA as an autoimmune disorder.
3. Discuss the impact of these changes on the patient's health or well-being.

JRA-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components of JRA.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with JRA as a life-altering illness that requires a change in lifestyle (**refer to [“JRA-LA Lifestyle Adaptations](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with JRA, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#)**.
6. Refer to a mental health agency or provider.

JRA-C COMPLICATIONS

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

STANDARDS:

1. Discuss complications of JRA such as joint destruction and uveitis.
2. Describe the signs/symptoms of common complications of JRA (increased pain, visual changes).

JRA-CM CASE MANAGEMENT

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

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”](#).

JRA-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

JRA-DP DISEASE PROCESS

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

STANDARDS:

1. Discuss that the cause of JRA is currently unknown.
2. Discuss that there are several types of JRA. Explain this patient’s type of JRA.

JRA-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
 - g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

JRA-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

JRA-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care including physical therapy and ophthalmology.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

JRA-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding juvenile rheumatoid arthritis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding JRA and dealing with issues.
2. Provide the help line phone number or Internet address (URL), such as <http://www.arthritis.org/how-to-care-for-yourself.php>

JRA-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.

4. Review the community resources available for help in achieving behavior changes.

JRA-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to juvenile rheumatoid arthritis.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

JRA-L LITERATURE

OUTCOME: The patient/family will receive literature about juvenile rheumatoid arthritis.

STANDARDS:

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

JRA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for JRA.

STANDARDS:

1. Discuss lifestyle adaptations specific to JRA, including non weight-bearing activities to rest joints.
2. Discuss that family may also require lifestyle adaptations to care for the patient.

3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

JRA-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

JRA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for JRA.

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.

JRA-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition, as it relates to JRA.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.

JRA-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient and may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

JRA-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:

- a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

JRA-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. Explain this may include visits with the physical therapist as well as home exercises. **Refer to [“PT - Physical Therapy.”](#)**
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.

JRA-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to JRA.

STANDARDS:

1. Discuss use of safety features to help prevent falls due to joint pain.
 - a. Wear flat shoes or socks when out of bed.
 - b. Avoid throw rugs, electrical cords, objects on the floor, unlevel or wet floors, and stairs.
 - c. Be aware of pets or small children playing on the floor.
 - d. Obtain assistance when getting up from bed or seated position.
 - e. Obtain and use assistive mobility devices, as recommended.
2. Discuss sports participation and the potential for permanent joint disability.

JRA-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.

2. Explain the role of effective stress management in JRA.
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.

JRA-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

JRA-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

JRA-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 participation with treatment plan.
2. Discuss therapies that may be utilized, such as exercise, medications, alternative therapies, joint injections, or surgery (such as joint replacement).
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

K**STONES - Kidney Stones****STONES-AP ANATOMY AND PHYSIOLOGY**

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

STANDARDS:

1. Explain the normal anatomy and physiology of the urinary system that consists of the kidneys, ureters, bladder, and urethra.
2. Discuss the changes to anatomy and physiology as a result of kidney stones that have not been passed.

STONES-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications related to kidney stones.

STANDARDS:

1. Discuss that normally smaller kidney stones will pass through the urinary system causing no serious damage or complications aside from pain and discomfort.
2. Explain that if the kidney stone gets so big that it starts to block the flow of urine, it can cause:
 - a. pressure to build in the affected kidney and ureter
 - b. stretching and spasm, resulting in severe pain
 - c. an increased risk of damage to the kidneys, infections, and bleeding
3. Describe the signs/symptoms of common complications of kidney stones:
 - a. severe pain in the lower back or side
 - b. groin pain
 - c. nausea and vomiting
 - d. blood in the urine
 - e. painful urination
 - f. fever and chills
 - g. urine that smells bad or looks cloudy

4. Explain that stone removing procedures will be considered if the stone is too large to pass on its own, if the stone is blocking the urine flow, or if the stone is causing urinary tract infection or kidney damage. Refer to [“STONES-TX Treatment”](#).

STONES-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the kidney stone disease process.

STANDARDS:

1. Explain that kidney stones are hardened mineral deposits that form in the kidney when the components of the urine - fluid and various minerals- are out of balance. Kidney stones can form when:
 - a. there is a decrease in urine volume (e.g., dehydration, UTI)
 - b. there is an excess of stone-forming substance in the urine (e.g., calcium oxalate, uric acid)
 - c. the urine is short of naturally occurring chemicals that keep crystals from sticking together and becoming stones
2. Discuss kidney stones are very tiny when they form, smaller than a grain of sand, but gradually over time can grow to the size of a pearl or larger. Stones may be smooth or jagged.
3. Explain that once the stone is formed, depending upon its size, it may stay in the kidney or travel down the urinary tract through the ureter and into the bladder where the stone is expelled with stored urine.
4. Explain that if the stone is too large to pass easily:
 - a. pain continues as the muscles in the wall of the narrow ureter try to squeeze the stone into the bladder
 - b. as the stone moves and the body tries to push it out, blood may appear in the urine, making the urine pink
 - c. as the stone moves down the ureter, closer to the bladder, a person may feel the need to urinate more often or feel a burning sensation during urination
5. Once the stone enters the bladder, the obstruction in the ureter is relieved and symptoms of the kidney stone are resolved.

STONES-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment

- b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
 3. 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.

STONES-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

STONES-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding kidney stones.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding kidney stones and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

STONES-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of kidney stones.

STANDARDS:

1. Discuss that most kidney stones are small enough to pass through the urinary tract on their own and managed safely at home until the stone is passed.
2. Explain home management techniques:
 - a. drink plenty of fluids to keep urine clear
 - b. walk to help move the stone through
 - c. use prescribed pain medications
 - d. strain urine and collect stone to be analyzed for mineral composition
 - e. discuss when to seek medical care
3. Discuss the implementation of hygiene and infection control measures.

STONES-L LITERATURE

OUTCOME: The patient/family will receive literature about kidney stones.

STANDARDS:

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

STONES-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

STONES-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for kidney stones.

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.

STONES-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to kidney stones.

STANDARDS:

1. Discuss diet changes that can reduce the risk of forming new stones.
 - a. drink plenty of fluids (water is best) to increase urine volume and keep urine pale yellow to clear
 - b. consume diets low in protein that help to prevent stone formation; (consume 6-8 ounces of beef, pork, poultry, and fish per day)
 - c. consume diets low in sodium that are effective in reducing stone formation (consume less than 2 grams (2,000 mg) of sodium per day)
 - d. consume a moderate amount of calcium in the diet
2. Explain that because different kidney stone types require specific dietary changes, referral to dietician to help develop an individualized plan may be indicated (e.g., calcium oxalate, uric acid stones).
3. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
4. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.

5. Discuss the importance of regular meals and adequate fluid intake.
6. Explain that a person who has a tendency to form kidney stones should consult a doctor or dietitian before taking large doses of vitamins or minerals supplements.

STONES-P PREVENTION

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

STANDARDS:

1. Discuss the importance of a workup (e.g. stone analysis, serum stone profile and 24 hour urine specimen) to assist in identification of fluid and dietary changes or medications to help prevent further stone formation.
2. Explain factors that can prevent the formation of kidney stones:
 - a. Drinking enough fluids is the most important guideline to prevent the formation of any kidney stone. If on fluid restriction, discuss this with the healthcare provider.
 - b. Dietary changes can lower the concentration of stone-forming chemicals in the urine. Diet changes can be individualized, specific to the type of stone. **Refer to [“STONES-N Nutrition”](#), [“STONES-MNT Medical Nutrition Therapy”](#).**
 - c. Use of some medications can be prescribed to help dissolve stones or prevent new ones from forming. The medication used depends on the type of kidney stone formed.
 - d. Treat and correct, if possible, any underlying conditions known to cause kidney stones (e.g., hyperthyroidism, sarcoidosis, distal tubular acidosis).
3. Explain that sometimes kidney stones cannot be prevented.

STONES-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

STONES-PRO PROCEDURE

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 of 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 for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

STONES-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

STONES-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 participation in the treatment plan.
2. Discuss that most kidney stones can be managed safely at home until the stone is passed. Refer to [**"STONES-HM Home Management"**](#).
3. Explain that other treatment therapies may include:
 - a. using a scope to remove stones
 - b. using sound waves to break up stones
 - c. using surgery to remove very large stones
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.

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

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

STANDARDS:

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

LAB-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining lab results and follow-up appointments.
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.

LAB-L LITERATURE

OUTCOME: The patient/family will receive literature about the laboratory procedure.

STANDARDS:

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

LAB-S SAFETY

OUTCOME: The patient/family will understand the procedures 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(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

LEAD - Lead Exposure/Lead Toxicity

LEAD-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of organs affected by lead, such as the brain and kidneys.
2. Discuss the changes to anatomy and physiology as a result of lead exposure and toxicity.
3. Discuss the impact of these changes on the patient's health or well-being.

LEAD-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to lead exposure and toxicity.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with lead exposure and toxicity as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with lead exposure and toxicity, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to ["AOD - Alcohol and Other Drugs"](#).**
6. Refer to a mental health agency or provider.

LEAD-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 10 μ g/dl can result in subtle neurobehavioral changes such as hyperactivity, lower IQ levels, and poor school performance.)
2. Explain that older children and adults with high bone lead levels may exhibit aggressive behavior and antisocial behaviors.
3. As appropriate, discuss the effects of long term high levels of lead exposure. These may include vomiting, abdominal pain, constipation, ataxia, seizures, papilledema, impaired consciousness and eventually coma. The latter of these symptoms are associated with acute lead encephalopathy.

LEAD-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.

LEAD-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of lead exposure and lead toxicity.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.

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.

LEAD-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding lead toxicity.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding lead toxicity and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

LEAD-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of lead exposure.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.

LEAD-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to lead exposure.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.

LEAD-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.

LEAD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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.

LEAD-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 dietitian for MNT.

LEAD-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 [“LEAD-N Nutrition”](#).
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.
 - j. Keep current with recalls of toys and other items.
3. Explain the importance of removing lead from clothing, shoes, and your body if you work in an industry where lead exposure is likely.

LEAD-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. Discuss the population groups to be screened:
- a. infants 6 months of age, and children one year of age through 6 years of age annually (when hand-to-mouth activity generally decreases)
 - b. older children with mental retardation who may have prolonged hand-to-mouth activity
 - c. pregnant women

LEAD-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 10 μ g/dl.
 - b. Venous blood testing - used as a confirmatory test upon which future testing or treatment will be based.
 - c. Urinary lead levels - usually used during chelation therapy to determine the response to therapy.
 - d. Hair lead levels - unreliable secondary to likelihood of contamination or lack of standardized interpretation tools.

- e. Discuss as appropriate the CDC's recommendation for follow-up testing and/or treatment based on venous blood lead levels.
- f. 10-19 μ g/dl repeat venous level in 3 months, try to identify sources of lead exposure.
- g. 20-44 μ g/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. 45-59 μ g/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. 60-69 μ g/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. 70 μ g/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.

LEAD-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. **Refer to ["LEAD-TE Tests"](#).**
2. Discuss as appropriate that children with blood lead level 45 μ gC/dl are often candidates for chelation therapy.
3. Explain, as appropriate, that chelation therapy for persons with lead encephalopathy can be life-saving and chelation for persons without lead encephalopathy may prevent symptom progression and further toxicity.
4. Discuss the agent to be used for chelation in persons who are to undergo chelation. Discuss the risks and benefits of treatment.
5. Explain that the treatment decision will be made by the patient and medical team after reviewing the results of diagnostic tests.

LD - Learning Disorders/Disabilities

LD-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to learning disorders.

STANDARDS:

1. Discuss the common difficulty in adjusting to learning disorders, which will require a change in lifestyle, including the potential need for accommodations for academia and employment (**refer to [“LD-LA Lifestyle Adaptations”](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with Learning Disorders, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#)**.
4. Refer to a mental health agency or provider.

LB-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications and common co-morbid conditions of Learning Disorders.

STANDARDS:

1. Explain that Learning Disorders are often associated with demoralization, low self-esteem, and deficits in social skills.
2. Explain that individuals with undiagnosed or untreated learning disorders have a higher than average incidence of Developmental Coordination Disorder, school drop-out rates, and difficulties in employment and social adjustment.
3. Explain that many adults with learning disabilities demonstrate autistic traits; and conversely those with a higher number of autistic traits were more likely to be profoundly learning disabled.
4. Explain that many individuals with Attention-Deficit/Hyperactivity Disorder (**refer to [“ADHD - Attention-Deficit/Hyperactivity Disorder”](#)**), Conduct Disorder (**refer to [“COND - Conduct Disorder”](#)**), Oppositional Defiant Disorder (**refer to [“ODD - Oppositional Defiant Disorder”](#)**), and Depressive Disorders (**refer to [“DEP - Depressive Disorders”](#)**) also have Learning Disorders.

LD-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in coping with Learning Disorders.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, school system, teachers, 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”](#).

LD-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 health and their perceptions of learning disabilities.

STANDARDS:

1. Explain that the current standardized tests of aptitude and achievement do not accurately reflect the Native American population in their standardization sample, and that the discrepancy between aptitude and achievement scores noted in individuals with learning disorders is characteristic of many Native American individuals without learning disabilities.
2. Discuss the efforts made to ensure that interpretation of intelligence test procedures and scores reflect adequate attention to the individual's ethnic or cultural background.
3. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
4. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

LD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of Learning Disorders.

STANDARDS:

1. Explain that Learning Disorders are a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning or mathematical abilities.

- a. Explain that these disorders are intrinsic to the individual and presumed to be due to neurological or Central Nervous System Dysfunctions.
- b. Explain that individuals can be diagnosed with more than one learning disability, and can range from mild to severe.
2. Discuss the symptoms of the Learning Disorder under consideration:
 - a. **Reading Disorder** includes difficulty identifying groups of letters, problems relating letters to sounds, reversals, chaotic spelling, failure to recognize words, hesitant oral reading, and word-by-word rather than contextual reading.
 - b. **Disorder of Written Expression**, known as dysgraphia, includes problems with letter formation and writing layout on the page, repetitions and omissions, punctuation and capitalization errors, “mirror writing” (writing right to left), and a variety of spelling problems.
 - c. **Mathematics Disorder**, known as dyscalculia, involves difficulty counting, reading and writing numbers, understanding basic math concepts, mastering calculations, and measuring. This type of disability may also involve problems with nonverbal learning, including spatial organization.
 - d. **Learning Disorders Not Otherwise Specified (NOS)** is for disorders in learning that do not meet the criteria for any specific Learning Disorder, which may include problems in all three areas that together interfere with academic achievement.
3. Discuss other specific learning disabilities as listed from professional sources:
 - a. **Dyslexia** involves a reading, writing, and/or speaking dysfunction, such as reading or pronouncing letters or words in reverse order.
 - b. **Dyspraxia** involves difficulty with fine motor skills, such as trouble with scissors or buttons.
 - c. **Auditory Processing Disorder** involves difficulty with language development and reading, such as difficulty anticipating how someone will end a sentence.
 - d. **Visual Processing Disorder** also involves difficulties with reading, writing, and math, such as difficulty distinguishing between “h” and “n.”
 - e. **Attention Deficit Hyperactivity Disorder** is also considered a Learning Disorder (refer to [“ADHD - Attention-Deficit/Hyperactivity Disorder”](#)) involving difficulty with concentration, focus, and impulsivity.
4. Discuss the efforts made to ensure that interpretation of intelligence test procedures and scores reflect adequate attention to the individual's ethnic or cultural background.
5. Explain that learning disabilities are usually life-long, although many individuals learn to compensate for their problems (refer to [“LD-TX Treatment”](#)).

LD-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in maintaining health and preventing injuries.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

LD-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of Learning Disorders and their complications.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

LD-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding learning disabilities.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding learning disabilities and dealing with issues and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

LD-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

LD-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.

LD-L LITERATURE

OUTCOME: The patient/family will receive literature about Learning Disorders.

STANDARDS:

1. Provide the patient/family with literature on the specific learning disabilities.
2. Discuss the content of the literature.

LD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for Learning Disorders and the complications associated with them.

STANDARDS:

1. Discuss lifestyle adaptations specific to necessary to cope with Learning Disorders, including:
 - a. School-related accommodations, which may include extra time for test-taking, a separate environment free from noise or distractions, or smaller classes or individualized tutoring
 - b. Work-related accommodations
2. Discuss that family may also require lifestyle adaptations to care for the patient, including extra time for tutoring or mentoring the family member and coping with emotional, behavioral, and cognitive complications.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available, including mental health professionals/school psychologists, social services, and school representatives.

LD-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy for problems associated with Learning Disabilities.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

LD-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to health and wellness.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Discuss the importance of regular meals and adequate fluid intake.
3. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
4. Refer to registered dietitian for MNT or other local resources as appropriate.

LD-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of complications associated with Learning Disorders.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

LD-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in adjusting to the emotional and behavior complications of Learning Disorders.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in reducing or eliminating emotional complications of Learning Disorders.
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.

LD-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential limitations, the expected benefits, and problems with non-testing in regards to learning disabilities.

STANDARDS:

1. Explain the tests that have been suggested to diagnose any Learning Disorders including the specific Intelligence Tests (I.Q. Tests) and achievement tests need to be conducted by trained psychologists or pediatricians with a specialty in child development:
 - a. method of testing
 - b. necessity, benefits, and limitations of tests to be performed, including cultural factors
 - c. any potential risk of refusal of recommended test(s)
 - d. how the results will be used for future decision-making
 - e. how to obtain the results of the test
2. Explain test results:
 - a. interpretation of test results with cultural, social, and spiritual variables factored in
 - b. follow-up tests may be ordered based on the results;
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

LD-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

LD-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options for Learning Disorders and the associated features.

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation with treatment plan.
 - a. Explain that specific educational assistance is the best treatment for individuals with learning disabilities.
 - b. Explain that remedial training in areas where a disabled child is weakest is best managed by trained teachers, reading specialists, or tutors in special classes or schools.
2. Discuss the parents' involvement in the treatment of the learning disorders, including:
 - a. Providing gentle understanding, emotional support, and opportunities for the child to experience success in other non-reading activities
 - b. Allowing a child to “burn-off” tensions and frustrations through sports or artistic activities
 - c. Participating in the Individualized Educational Plans (IEP) developed by the school district and other members of the care team
3. Explain the importance of treating any associated conditions or co-occurring disorders, such as depressive disorders (**refer to [“DEP - Depressive Disorders”](#)**), ADHD (**refer to [“ADHD - Attention-Deficit/Hyperactivity Disorder”](#)**), social problems, and behavioral problems, such as Conduct Disorder (**refer to [“COND - Conduct Disorder”](#)**).

4. Explain that the treatment plan will be made by the patient and treatment team after reviewing available options. Explain that treatment may vary according to the patient's life circumstances, severity of the condition, the patient/family's participation in the choices, and available resources

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 guiding medical care and decision making to best serve the patient's care preferences.

STANDARDS:

1. Explain that many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is unable to provide guidance at the time that decisions need to be made.
3. Explain that Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences for care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer,) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.
6. Refer to ["ADV - Advance Directives"](#).

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-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to liver disease.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with liver disease as a life-altering illness that requires a change in lifestyle (**refer to [“LIV-LA Lifestyle Adaptations”](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with liver disease, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#)**.
6. Refer to a mental health agency or provider.

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.

LIV-CM CASE MANAGEMENT

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

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”](#).**

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. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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 obesity can contribute to a fatty liver.
4. Explain that cryptogenic cirrhosis is caused by unknown etiology.

5. Explain that certain viral infections such as hepatitis may result in destruction of liver cells, cirrhosis or hepatic cancer.
6. 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

LIV-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding liver disease.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding liver disease and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

LIV-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and

substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.

3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

LIV-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to liver disease.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

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. Emphasize the importance of the patient's adaptation to a healthier and lower risk lifestyle in order to minimize the complications of liver disease.
3. Review the community resources available to assist the patient in making lifestyle changes and make referrals as needed.

LIV-M MEDICATIONS

OUTCOME: The patient/family will understand the 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

LIV-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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 and modifying protein intake.
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 than 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-P PREVENTION

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

STANDARDS:

1. Discuss the need for immunization against Hepatitis.
2. Explain the need to avoid liver toxins, e.g., alcohol, acetaminophen, uncooked seafood.

LIV-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

LIV-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed

- c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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.

LOMA - Lymphoma

LOMA-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family 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 many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is able to provide guidance at the time that decisions need to be made.
3. Explain that the Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences of care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.

LOMA-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of the lymphatic system including lymphocytes, lymph nodes, bone marrow, and associated organs.
2. Discuss changes to anatomy and physiology as a result of lymphoma.
3. Discuss the impact of these changes on the patient's health or well-being.

LOMA-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to lymphoma.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with lymphoma as a life-altering illness that requires a change in lifestyle (**refer to [“LOMA-LA Lifestyle Adaptations”](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with lymphoma, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#)**.
6. Refer to a mental health agency or provider.

LOMA-C COMPLICATIONS

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

STANDARDS:

1. Discuss common complications of lymphoma.
2. Describe the signs/symptoms of common complications of lymphoma.
3. Explain that many therapies for lymphoma depress the immune system and that infection is a major risk.
4. Discuss that nausea and vomiting are frequent side effects of many lymphoma therapies and that these can often be successfully medically managed.
5. Discuss that pain may be a complication of the disease process or the therapy. **Refer to [“PM - Pain Management”](#)**.

LOMA-CM CASE MANAGEMENT

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

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”](#).

LOMA-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

LOMA-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the _type of lymphoma and its disease process.

STANDARDS:

1. Explain that there are many different types of lymphoma and provide the specific type/site and causative/risk factors, as appropriate.
2. Discuss signs and symptoms and the usual progression of the specific lymphoma.
3. Discuss the lymphoma staging and prognosis.

LOMA-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction

- f. infection control principles, including proper disposal of associated medical supplies
- g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

LOMA-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

LOMA-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

LOMA-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding lymphoma.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding lymphoma and dealing with issues.
2. Provide the help line phone number or Internet address (URL) such as:
 - a. American Cancer Society: 1-800-ACS-2345
 - b. National Cancer Institute, Cancer Information Service: 1-800-4-CANCER [1-800-422-6237]; TTY (for deaf and hard-of-hearing callers) 1-800-332-8615
 - c. Leukemia & Lymphoma Society: 1-800-955-4572
 - d. Lymphoma Research Foundation: 1-800-500-9976

LOMA-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of lymphoma.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

LOMA-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

LOMA-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to lymphoma.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

LOMA-L LITERATURE

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

STANDARDS:

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

LOMA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for lymphoma.

STANDARDS:

1. Discuss lifestyle adaptations specific to lymphoma.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

LOMA-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

LOMA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for lymphoma.

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.

LOMA-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to lymphoma.

STANDARDS:

1. Explain 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.

LOMA-P PREVENTION

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

STANDARDS:

1. Explain that the etiology of lymphoma is not known, however some potential risks may include:
 - a. viral infection
 - b. immunodeficiency
 - c. drug or chemical exposure
 - d. family history
2. Emphasize the importance of the early cancer detection. Encourage the patient to come in early if signs of cancer are detected (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).

LOMA-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care and fertility as it relates to lymphoma treatment.

STANDARDS:

1. Discuss the possible effects of lymphoma treatment on fertility and options that might be available.

2. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
3. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
4. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
5. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
6. Refer for medical and psychosocial support services for any risk factor identified.

LOMA-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management”](#).**

3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

LOMA-PRO PROCEDURE

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 of 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 for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

LOMA-SHS SECOND-HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Explain that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, carcinogens.
3. Explain the increased risk of illness when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia, SIDS, and lung cancer.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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.

LOMA-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in lymphoma.
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.

LOMA-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)

- d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

LOMA-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

LOMA-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 participation in 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 watchful waiting, surgery, radiation therapy, and pharmacologic therapy (chemotherapy) 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.

LOMA-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

LYME - Lyme Disease

LYME-C COMPLICATIONS

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

STANDARDS:

1. Explain that complications of Lyme Disease are rare, but they can be serious. Discuss complications that can affect the nervous system, joints, and heart.
2. Explain that prompt treatment usually prevents later heart, nerve, and joint symptoms.

LYME-DP DISEASE PROCESS

OUTCOME: The patient/family/caregiver will understand Lyme Disease.

STANDARDS:

1. Explain that Lyme Disease is caused by a bacteria from an infected tick and if left untreated, can cause inflammation in many systems of the body.
2. Discuss the symptoms of Lyme Disease in each phase:
 - a. Early symptoms include a solid red or bull's-eye rash, swelling of lymph glands near the tick bite, and generalized achiness.
 - b. If untreated, the bacterium may spread through the bloodstream to the rest of the body resulting in multiple skin rashes and flu-like symptoms.
 - c. Late stage symptoms may occur months to even years after the onset of infection and can affect the joints, nerves, heart, and brain.

LYME-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

LYME-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding Lyme Disease.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding Lyme Disease and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

LYME-L LITERATURE

OUTCOME: The patient/family will receive literature about Lyme Disease.

STANDARDS:

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

LYME-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

LYME-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for Lyme 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.

LYME-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of becoming infected with Lyme Disease.

STANDARDS:

1. Discuss ways of avoiding tick bites using personal protection.
 - a. Wear enclosed shoes and light colored clothing
 - b. Tuck pant legs into socks
 - c. Apply tick repellents (permethrin or DEET)
2. Discuss the importance of prompt, careful inspection, and removal of ticks. The use of mirrors may help with self inspection.
3. Explain the importance of lawn maintenance to eliminate unused furniture / mattresses, overgrown weeds, and other breeding areas.
4. Discuss the use of pet flea/tick collars and medicines to prevent the spread of ticks inside the home.

LYME-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing

- b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
- a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

LYME-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

LYME-TX TREATMENT

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

STANDARDS:

1. Discuss that prompt tick removal should be done to minimize exposure. Ticks should be removed with tweezers close to the skin.
2. Discuss the types of treatment used for Lyme Disease. Explain that the treatment plan will be based on individual symptoms. Emphasize the importance of active participation by the patient/family in the treatment plan.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.

M**MSAF - Medical Safety****MSAF-C COMPLICATIONS**

OUTCOME: The patient and/or family will understand the importance of preventing and managing medical errors.

STANDARDS:

1. Discuss with patient/family members that it is important for them to take an active role in the patient's 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/family will understand the importance of follow-up for medical safety.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

MSAF-HY HYGIENE

OUTCOME: The patient/family will understand the importance of hygiene in preventing and controlling the spread of infection.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.

- b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
- c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

MSAF-I INFORMATION

OUTCOME: The patient/family will be able to identify the patient's 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 the patient's primary physician.
3. Inform the patient/family of the reporting methods related to care, treatment, and services and patient safety issues.
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 the providers of any allergies or adverse medication reactions that the patient may have experienced.
3. Discuss the importance of being able to identify medications by the name, strength, purpose, and dosing directions and calling attention to the provider, pharmacist, or nurse when the medications provided do not appear to be correct. 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.
4. Discuss the storage and disposal of the medication:
 - a. Use of safety caps and non-safety caps
 - b. Keep medicine and pill boxes out of reach of children
 - c. Keep medication in correctly labeled original container. Do not mix or put medications into unlabeled containers, with the exception of medication pill boxes.
 - d. Dispose of medications appropriately:
 - i. Follow specific disposal instructions on label
 - ii. Take unused medications to community drug take-back programs
 - iii. If disposing of medications in the garbage, take out of the original container and mix with coffee grounds, cat litter, or dirt. Put them in a sealable bag, empty can, or other container.
 - iv. Place needles or syringes in a glass container or heavy plastic container and dispose of in household garbage.
 - v. Do not flush medications down the toilet unless instructed.
 - vi. If unsure on how to dispose of medications, talk with the pharmacist.
5. Explain the importance of not sharing or selling medications with others.

MSAF-P PREVENTION

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

STANDARDS:

1. 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. Discuss the types of medical errors, which may include but not limited to:

- a. Medicine
 - b. Surgery/Procedure
 - c. Diagnosis
 - d. Equipment
 - e. Test reports
 - f. Hospital acquired infections
2. Discuss with patient/family members that it is important for them to take an active role in the patient's healthcare. Instruct patient that if necessary, a family member or friend may attend the appointment.
 3. Discuss the importance of knowing who the patient may contact for medical advice and information and concerns regarding the care, treatment, services, and patient safety issues. Encourage patient/family to report concerns about safety.
 4. Discuss infection prevention measures of hand hygiene practices, respiratory hygiene practices, and contact precautions according to the patient's condition.
 5. Discuss the importance of all healthcare workers being aware of the patient's health and care and having the patient's medical record available.
 6. Explain that when possible, select a hospital that has experience in the procedures that the patient needs.

MSAF-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site

- d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

MSAF-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

M - Medications

M-ADD ADDITION

OUTCOME: The patient/family will have an awareness of addiction potential to some prescription medications.

STANDARDS:

1. Discuss medications should be taken as prescribed. Feeling the need to take more medicine than prescribed may become problematic and should be discussed with a medical provider.
2. Explain that some medicines have higher addiction potential than others.
3. Explain that some conditions do require large amounts of medication to control symptoms. Tolerance and addiction are different and some people may become medically dependent on some medications. This is not considered addiction.
4. Refer to treatment programs as appropriate. **Refer to [“AOD - Alcohol and Other Drugs”](#).**

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 certain 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. 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.

2. Discuss the importance of informing all healthcare providers of medications taken, including prescription, over-the-counter, herbal, supplements, and traditional medicine (medication reconciliation).
3. Discuss signs/symptoms that should prompt for immediate follow-up.
4. Discuss the importance of follow up of medication therapy to assess adverse drug effects, safety, and efficacy of the prescribed medications.
5. Discuss the procedure for obtaining refills and renewals for medications.
6. 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. Describe the name, strength, purpose, dosing directions, and storage of the medication. Discuss plans for managing missed doses.
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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

M-L LITERATURE

OUTCOME: The patient/family will receive literature about the medication(s) prescribed.

STANDARDS:

1. Provide the patient/family with literature on 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 correctly fill the medication box.
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. 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/family will be able to demonstrate correct technique for 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 inhaler properly.
2. Review the importance of using consistent inhalation technique.
3. Discuss the purpose of a spacer device. Instruct and demonstrate proper technique for spacer use. Discuss the proper care and cleaning of spacers.

M-MR MEDICATION RECONCILIATION

OUTCOME: The patient/family will receive and review a printed medication profile.

STANDARDS:

1. Emphasize the importance of maintaining an accurate and updated medication profile.
2. Provide the patient/family with a copy of the patient's medication profile.
3. Discuss the content of the medication profile with the patient/family. Emphasize that the profile should consist of all medications including prescription, over-the-counter, herbals, traditional, and medications dispensed at any pharmacy.
4. Emphasize the need to provide a copy of the complete medication profile at every medical visit.

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-S SAFETY

OUTCOME: The patient/family will understand factors associated with medication safety.

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 the providers of any allergies or adverse medication reactions that the patient may have experienced.
3. Discuss the importance of being able to identify medications by the name, strength, purpose, and dosing directions and calling attention to the provider, pharmacist, or nurse when the medications provided do not appear to be correct. 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.
4. Discuss the storage and disposal of the medication:
 - a. Use of safety caps and non safety caps
 - b. Keep medicine and pill boxes out of reach of children
 - c. Keep medication in correctly labeled original container. Do not mix or put medications into unlabeled containers, with the exception of medication pill boxes.
 - d. Dispose of medications appropriately:
 - i. Follow specific disposal instructions on label
 - ii. Take unused medications to community drug take-back programs
 - iii. If disposing of medications in the garbage, take out of the original container and mix with coffee grounds, cat litter, or dirt. Put them in a sealable bag, empty can, or other container.

- iv. Place needles or syringes in a glass container or heavy plastic container and dispose of in household garbage.
 - v. Do not flush medications down the toilet unless instructed.
 - vi. If unsure on how to dispose of medications, talk with the pharmacist.
5. Explain the importance of not sharing or selling medications with others.

M-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

MNG - Meningitis

MNG-ADV **ADVANCE DIRECTIVE**

OUTCOME: The patient/family 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 many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is able to provide guidance at the time that decisions need to be made.
3. Explain that the Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences of care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.

MNG-AP **ANATOMY AND PHYSIOLOGY**

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

STANDARDS:

1. Explain the normal anatomy and physiology of the brain and spinal cord and other associated central nervous system structures.
2. Discuss changes to anatomy and physiology as a result of meningitis.
3. Discuss the impact of these changes on the patient's health or well-being.

MNG-BH **BEHAVIORAL AND EMOTIONAL HEALTH**

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components as it relates to meningitis.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with meningitis as a life-altering illness that requires a change in lifestyle (**refer to [“MNG-LA Lifestyle Adaptations”](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with meningitis, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#)**.
6. Refer to a mental health agency or provider.

MNG-C COMPLICATIONS

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

STANDARDS:

1. Discuss common complications of meningitis. The complications of meningitis can be severe. The longer you or your child has the disease without treatment, the greater the risk of seizures and permanent neurological damage, including:
 - a. Hearing loss
 - b. Blindness
 - c. Memory difficulty
 - d. Loss of speech
 - e. Learning disabilities
 - f. Behavior problems
 - g. Brain damage
 - h. ParalysisOther complications may include:
 - i. Kidney failure
 - j. Adrenal gland failure
 - k. Shock
 - l. Death
2. Describe the signs/symptoms of common complications of meningitis.

MNG-CM CASE MANAGEMENT

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

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”](#).**

MNG-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

MNG-DP DISEASE PROCESS

OUTCOME: The patient/family will understand meningitis.

STANDARDS:

1. Discuss the disease process of meningitis. Meningitis usually results from a viral infection, but the cause may also be a bacterial infection. Less commonly, a fungal infection may cause meningitis. Because bacterial infections are the most serious and can be life-threatening, identifying the source of the infection is an important part of developing a treatment plan.
 - a. Acute bacterial meningitis usually occurs when bacteria enter the bloodstream and migrate to the brain and spinal cord. But it can also occur when bacteria directly invade the meninges, as a result of an ear or sinus infection or a skull fracture. A number of strains of bacteria can cause acute bacterial meningitis.

- b. Viral meningitis is usually mild and often clears on its own within two weeks. Each year, viruses cause a greater number of cases of meningitis than do bacteria. A group of viruses known as enteroviruses are responsible for most viral meningitis cases in the United States. Many viral meningitis episodes never have a specific virus identified as the cause. The most common signs and symptoms of enteroviral infections are rash, sore throat, diarrhea, joint aches and headache. These viruses tend to circulate in late summer and early fall. Viruses such as herpes simplex virus, La Crosse virus, West Nile virus and others also can cause viral meningitis.
 - c. Chronic forms of meningitis occur when slow-growing organisms invade the membranes and fluid surrounding the brain. Although acute meningitis strikes suddenly, chronic meningitis develops over two weeks or more. Nevertheless, the signs and symptoms of chronic meningitis- headaches, fever, vomiting and mental cloudiness- are similar to those of acute meningitis. This type of meningitis is rare.
 - d. Fungal meningitis is relatively uncommon and causes chronic meningitis. Occasionally it can mimic acute bacterial meningitis. Cryptococcal meningitis is a common fungal form of the disease that affects people with immune deficiencies, such as AIDS. It's life-threatening if not treated with an antifungal medication.
 - e. Meningitis can also result from noninfectious causes, such as drug allergies, some types of cancer and inflammatory diseases such as lupus.
2. Explain the disease process of meningitis.
 - a. The hallmark signs of meningitis are sudden fever, severe headache, and a stiff neck. In more severe cases, neurological symptoms may include nausea and vomiting, confusion and disorientation, drowsiness, sensitivity to bright light, and poor appetite.
 - b. Meningitis often appears with flu-like symptoms that develop over 1-2 days. Distinctive rashes are typically seen in some forms of the disease. Meningococcal meningitis may be associated with kidney and adrenal gland failure and shock.

MNG-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment

- d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
 3. 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.

MNG-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

MNG-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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. **Refer to ["MNG-C Complications"](#).**
5. Discuss the availability of community resources and support services and refer as appropriate.

MNG-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding meningitis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding meningitis and dealing with issues.
2. Provide the help line phone number or Internet address (URL), such as

<http://www.cdc.gov/meningitis/index.html>

http://www.ninds.nih.gov/disorders/encephalitis_meningitis/encephalitis_meningitis.htm

Meningitis Foundation of America, Inc.
supportmfa@musa.org
Tel: 480-270-2652

<http://www.musa.org>

National Meningitis Association
support@nmaus.org
Tel: 866-FONE-NMA (366-3662)

<http://www.nmusa.org>

MNG-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of long-term recovery from meningitis.

STANDARDS:

1. Explain the home management techniques. Patients with mild viral meningitis may be allowed to stay at home, while those who have a more serious infection may be hospitalized for supportive care. Patients with mild cases, which often cause only flu-like symptoms, may be treated with fluids, bed rest (preferably in a quiet, dark room), and analgesics for pain and fever.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

MNG-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

MNG-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to meningitis.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

MNG-L LITERATURE

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

STANDARDS:

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

MNG-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for long-term recovery from meningitis.

STANDARDS:

1. Discuss lifestyle adaptations specific to meningitis.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

MNG-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

MNG-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for long-term recovery from meningitis.

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.

MNG-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to long-term recovery from meningitis.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

MNG-P PREVENTION

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

STANDARDS:

1. Discuss prevention of meningitis. Meningitis typically results from contagious infections. Common bacteria or viruses that can cause meningitis can spread through coughing, sneezing, kissing, or sharing eating utensils, a toothbrush or a cigarette. The patient is also at increased risk if living or working with someone who has the disease. These steps can help prevent meningitis:
 - a. Careful hand washing is important to avoiding exposure to infectious agents. Teach children to wash their hands often, especially before they eat and after using the toilet, spending time in a crowded public place or petting animals. Show them how to wash their hands vigorously, covering both the front and back of each hand with soap and rinsing thoroughly under running water.
 - b. Maintain the patient's immune system by getting enough rest, exercising regularly, and eating a healthy diet with plenty of fresh fruits, vegetables and whole grains.
 - c. When the patient needs to cough or sneeze, be sure to cover the mouth and nose. Reduce the risk of meningitis caused by listeriosis if the patient is pregnant by cooking meat thoroughly and avoiding cheeses made from unpasteurized milk.
2. Explain that some forms of bacterial meningitis are preventable with the following vaccinations:
 - a. Haemophilus influenzae type b (Hib) vaccine. Children in the United States routinely receive this vaccine as part of the recommended schedule of vaccines, starting at about 2 months of age. The vaccine is also recommended for some adults, including those who have sickle cell disease or AIDS and those who don't have a spleen.
 - b. Pneumococcal conjugate vaccine (PCV7). This vaccine is also part of the regular immunization schedule for children younger than 2 years in the United States. In addition, it's recommended for children between the ages of 2 and 5 who are at high risk of pneumococcal disease, including children who have chronic heart or lung disease or cancer.
 - c. Pneumococcal polysaccharide vaccine (PPSV). Older children and adults who need protection from pneumococcal bacteria may receive this vaccine. The Centers for Disease Control and Prevention recommends the PPSV vaccine for all adults older than 65, for younger adults and children who have weak immune systems or chronic illnesses such as heart disease, diabetes or sickle cell anemia, and for those who don't have a spleen.
 - d. Meningococcal conjugate vaccine (MCV4). The Centers for Disease Control and Prevention recommends that a single dose of MCV4 be given to children ages 11 to 12 or to any children ages 11 to 18 who haven't yet been vaccinated. However, this vaccine can be given to younger children who are at high risk of bacterial meningitis or who have been exposed to someone with the disease. It is approved for use in children as young as 9 months old. It is also used to

vaccinate healthy people who have been exposed in outbreaks but have not been previously vaccinated.

MNG-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

MNG-PRO PROCEDURE

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 of 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 for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

MNG-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of recovery from meningitis.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

MNG-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in managing of complications of meningitis.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in managing of complications of meningitis.
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.

MNG-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing (i.e., Neurological examination, laboratory testing of blood, urine, or bodily secretions, throat culture, lumbar puncture for cerebrospinal fluid collection and analysis, CT scan, MRI, or EEG.)
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

MNG-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

MNG-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that early treatment of bacterial meningitis with antibiotics is important to its outcome.
 - a. Antibiotics may be necessary through an IV. Antibiotics may also be given to prevent other bacterial infections. Appropriate antibiotic treatment for most types of meningitis can reduce the risk of dying from the disease.
 - b. Infected sinuses may need to be drained. Corticosteroids such as prednisone may be ordered to relieve brain pressure and swelling and to prevent hearing loss that is common in patients with Haemophilus influenza meningitis. Pain medicine and sedatives may be given to make patients more comfortable. Lyme disease is treated with intravenous antibiotics.
 - c. Unlike bacteria, viruses cannot be killed by antibiotics (an exception is the herpes virus, which may be treated with antiviral drugs). Anticonvulsants may be prescribed to prevent seizures and corticosteroids may be prescribed to reduce brain inflammation. If inflammation is severe, pain medicine and sedatives may be prescribed to make the patient more comfortable.
 - d. Acute disseminated encephalomyelitis is treated with steroids. Fungal meningitis is treated with intravenous antifungal medications.
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.

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-CRC COLORECTAL CANCER SCREENING

OUTCOME: The patient will understand the importance of colorectal cancer screening as it relates to maintaining optimal health.

STANDARDS:

1. Explain that screening for colorectal cancer should begin at age 50 or sooner if there is a family history of cancer. Explain that diagnosing cancer at the earliest stage often provides the best chance for a cure.
2. Discuss the following risk factors: older age, African American race, personal history of colorectal cancer or polyps, history of ulcerative colitis or Crohn's disease, genetic syndromes, family history of colon cancer or colon polyps, low-fiber and high fat diet, sedentary lifestyle, diabetes, obesity, smoking, heavy alcohol use, radiation therapy for previous cancers.

3. Discuss environmental factors that may contribute to the development of colorectal cancer such as asbestos, benzene, and cigarette smoke.
4. Discuss available techniques and recommended intervals for screening for colorectal cancer, as appropriate. Discuss necessary pre-test preparation including foods to avoid, medications to stop or start, bowel preparation, and testing procedure.
 - a. Fecal Occult Blood Testing
 - b. Sigmoidoscopy
 - c. Colonoscopy
5. Discuss the importance of follow-up for results, and further testing if needed for definitive diagnosis.

MH-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

MH-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.

STANDARDS:

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

MH-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in men's health.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, penis, gland, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

MH-IM IMMUNIZATIONS

OUTCOME: The patient will understand the immunizations necessary for preventing communicable diseases. **Refer to ["IM - Immunizations"](#).**

STANDARDS:

1. Discuss the schedule for recommended immunizations and illnesses they prevent. Review when the following immunizations would be used, as appropriate:
 - a. Tetanus
 - b. Pneumonia
 - c. Influenza
 - d. MMR (measles, mumps, rubella)
 - e. HPR (for certain types of cervical cancer)
 - f. Hepatitis A and B
 - g. Meningococcal
 - h. Zoster (shingles)
2. Discuss the side effects and potential adverse reactions that are common to this immunization.
3. Discuss the potential consequences of vaccine refusal.
4. Discuss the treatment of side effects and home care after immunizations.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.

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.

MH-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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-PCC PRE-CONCEPTION CARE

OUTCOME: The patient will understand the importance of pre-conception planning.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. avoiding tobacco exposure
 - b. encouraging tobacco cessation, if applicable
 - c. avoiding alcohol or other drugs
 - d. staying safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - e. staying current on immunizations
 - f. limiting exposure to occupational hazards
 - g. screening and treatment for STIs, including HIV
2. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues with partner such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
3. Discuss the man's perceived role in child rearing and the importance of discussing this with partner. This may include primary or supportive roles and legal responsibilities.

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-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-SX SEXUALITY

OUTCOME: The patient will understand the important aspects of sexuality.

STANDARDS:

1. Discuss that the decision to have sex is an individual decision. Peer pressure to have sex can be intense. The decision to have sex should always be discussed between partners.
2. Discuss healthy sexual behavior:
 - a. monogamous relationships
 - b. consensual sex
 - c. open and honest conversations with partner about sexual likes and dislikes
 - d. family planning and use of effective birth control
3. Explain sexual terms such as orgasm, foreplay, ejaculation, or any other terms unfamiliar to patient. Also explain what to expect during intercourse and symptoms that should be reported to a healthcare provider.
4. Discuss the importance of making a reproductive plan and pre-conception care when applicable.
5. Explain that promiscuous sexual behavior substantially increases the risk of sexually transmitted infections. These infections can lead to ectopic pregnancy, infertility, systemic infections, or chronic pelvic pain. Also emphasize that HIV, hepatitis, and herpes can be sexually transmitted and have no cures.
6. Emphasize that abuse, (i.e., sexual, emotional, or physical) should not be tolerated. Emphasize the importance of reporting domestic violence to the proper law enforcement and child welfare/protective agencies and the patient's healthcare provider. Discuss the availability of shelters and other support options in the area. Offer a list of resources and make referrals as appropriate. **Refer to [“DVV-IR Information and Referral](#).**

MH-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test

2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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.

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-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to menopause.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of menopause that requires a change in lifestyle (**refer to [“MPS-LA Lifestyle Adaptations”](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in menopause, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#)**.
6. Refer to a mental health agency or provider.

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.
 - 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. Less hair on the head, possible increase of hair on face
2. Explain how the complications/symptoms of menopause are related to decreased estrogen and other hormones.

MPS-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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. Emphasize the importance of follow-up care, including the importance of correcting problems that may develop.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding menopause.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding menopause and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

MPS-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.

- d. Practice new knowledge.
- e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

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. Discuss that hormone replacement therapy (HRT) is an option to relieve the symptoms of menopause and may protect against osteoporosis.
1. Explain that HRT has risks. It can increase your risk of breast cancer, heart disease, and stroke. Certain types of HRT have a higher risk, and each woman's own risks can vary depending upon her health history and lifestyle. If HRT is prescribed, it should be the lowest dose that helps and for the shortest time needed. Taking hormones should be re-evaluated every six months.
2. Describe the name, strength, purpose, dosing directions, and storage of the medication.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate. Urge caution with herbal remedies.
4. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

MPS-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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 dietitian, 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). Discuss the possible results of non-treatment and any potential problems related to recuperation.
2. Explain the process and what to expect before, during, and after the procedure.
3. Discuss the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

MPS-S SAFETY

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"](#) and ["FALL - Fall"](#).
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, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

MNTL - Mental Health

MNTL-AM ANGER MANAGEMENT

OUTCOME: The patient/family will apply anger management skills, and learn appropriate anger expression.

STANDARDS:

1. Explain/review the elements of the anger management skills under consideration:
 - a. Fair fighting techniques
 - b. Identifying the level or severity of the anger, (i.e., recognizing anger)
 - c. The effects of anger on the body and mind
 - d. Identifying self-talk and its influence on anger
 - e. Identifying the payoffs
 - f. The effects of suppression or repression of anger
 - g. Expressing/communicating anger appropriately (i.e., directing anger)
 - h. Aggression, passivity, and assertiveness
 - i. Understanding the source(s) of anger
2. Discuss the specific skills, homework, and applications regarding anger management, including:
 - a. Anger journal
 - b. Time out procedures
 - c. Mindfulness and gaining distance from anger
 - d. Expressing anger appropriately
 - e. Treating the source of the anger
 - f. Problem solving skills and constructive conflict resolution (refer to [“MNTL-CR Conflict Resolution”](#))
 - g. Release techniques (e.g., exercise, meditation, hate letters, etc.)

MNTL-AS ASSERTIVENESS SKILLS

OUTCOME: The patient/family will apply assertiveness skills and ways of meeting their needs.

STANDARDS:

1. Discuss assertive behavior, and explore the patient’s historical obstacles to assertive behavior, including childhood and family dynamics, fears of the reaction of others.

2. Discuss techniques for assertive communication and behavior, including:
 - a. Remaining firm and decisive
 - b. Goal-setting
 - c. Problem solving and constructive conflict resolution (refer to [“MNTL-CR Conflict Resolution”](#))
 - d. Expressing interest in others/mutual respect for self and others
 - e. Practicing assertive communication and behavior
 - f. Establishing appropriate boundaries
 - g. Learning way to trust one's own judgment

MNTL-CD COGNITIVE DISTORTIONS

OUTCOME: The patient/family will identify and alter the distortions in thinking.

STANDARDS:

1. Explain that cognitive distortions are exaggerated or irrational thoughts and beliefs, also known as logical fallacies, which may cause or perpetuate depression, anxiety, and other mental disorders, as well as interfere with relationships or normal daily functioning.
2. Discuss the distortions potentially noted in the patient/family:
 - a. **Black and white/All or nothing thinking** involves thinking in absolute terms, using words such as 'always', 'never', 'every'.
 - b. **Over-generalization** involves taking isolated cases and using them to make wide generalizations.
 - c. **Jumping to conclusions** involves drawing conclusions from little or not evidence, including:
 - i. **mind-reading:** assuming special knowledge of others, or expecting others to have special knowledge of one's self.
 - ii. **fortune-telling:** exaggerating how things will turn out before they happen.
 - d. **Disqualifying the positive** involves continually de-emphasizing or “shooting down” the positive for arbitrary or ad hoc reasons.
 - e. **Emotional reasoning** involves assuming that one's feelings reflect reality.
 - f. **Magnification and minimization** involves distorting aspects of memories or situations that they do not correspond to objective reality.
 - g. **Catastrophizing** involves focusing on the worst possible outcome, however unlikely, and believing that this uncomfortable situation is “unbearable.”

- h. **Should statement** involves the rigid implication that things will always apply no matter the circumstances.
 - i. **Labeling or mislabeling** involves explaining behaviors or events simply by naming them.
 - j. **Personalization** involves attributing personal responsibility for things over which one has no control.
 - k. **Errors in blaming** involve attributing responsibility to others for things over which they have no control.
3. Discuss methods for observing their own thoughts and “self-talk,” and how to change or correct the faulty thinking.

MNTL-COM COMMUNICATION SKILLS

OUTCOME: The patient/family will learn how to apply communication skills in their personal or professional life.

STANDARDS:

1. Explain the specific skills necessary for effective communication:
 - a. Expressive skills, such as use of “I” statements, conveying accurate information simply, and anticipation of assumptions and potentially defensive reactions.
 - b. Listening skills such as mirroring, validation, and empathy before responding.
 - c. Patience and attunement to timing, emotional reactions, and fair fighting techniques.
2. Discuss the importance of attunement to verbal and non-verbal communication, including body language, cultural differences, and the context.
3. Demonstrate or role-play effective communication.

MNTL-COP COPING SKILLS

OUTCOME: The patient/family will learn to build adaptive coping strategies in efforts to improve stress tolerance and mental health conditions.

STANDARDS:

1. Discuss the importance of developing internal coping skills, as opposed to unhealthy, external sources, such as drugs, alcohol, sex, and co-dependency.
2. Explain/review the ways of internalizing coping skills, including:
 - a. Breathing and other relaxation exercises
 - b. Mindfulness Based Stress Reduction/Being present

- c. Appropriate feelings expression/Talk to a trusted party as soon as problems arise
- d. Safe place for exercises, imagery
- e. Affect Containment/Container exercises
- f. Grounding exercises
- g. Visualization techniques
- h. Writing/Art (i.e., organizing and slowing down one's thoughts)
- i. Learning to observe thoughts and feelings objectively
- j. Take responsibility for one's feelings and life (i.e., avoid victim stance)
- k. Recognizing distorted thoughts (refer to [“MNTL-CD Cognitive Distortions”](#))

MNTL-CR CONFLICT RESOLUTION

OUTCOME: The patient/family/caregiver will learn skills for effective conflict resolution.

STANDARDS:

1. Discuss the mindset and attitude necessary for effective conflict resolution:
 - a. Normalize or reframe conflict as essential for healthy relationship as a means for dealing with differences. When handled in a respectful and positive way, conflict can result in opportunities for growth.
 - b. Explain that problems will continue to surface and may worsen if conflict is avoided.
 - c. Explain that successful conflict resolution depends on one's ability to regulate stress and one's own emotions.
 - d. Explain that psychotherapy may be necessary to address the source of strong emotional reactions if it continues to interfere with resolution.
2. Discuss the skills necessary for healthy conflict resolution within the context of the culture of the patient:
 - a. The capacity to recognize and respond to the things that matter to the other person
 - b. Pay attention to the feelings being expressed
 - c. Seek win-win solutions, and avoid the tendency to be “right”
 - d. Calm, non-defensive, and respectful reactions
 - e. A readiness to forgive and forget, and to move past the conflict without holding resentments or anger
 - f. The ability to seek compromise and avoid punishing

- g. A belief that facing conflict head-on is the best thing for both sides
- h. Fair fighting techniques

MNTL-DEF DEFENCES/RESISTANCE

OUTCOME: The patient/family will become aware of their defensive reactions, and develop mature responses to problems.

STANDARDS:

1. Explain the normal tendency of individuals to unconsciously resist the change they are seeking, and the ability to make more conscious choices with awareness.
2. Explain the defense under consideration.
3. Acknowledge the vulnerability in lowering defenses, and emphasize the importance of choosing the context to do so (e.g., therapeutic settings, intimate partner, etc.).
4. Assist the patient/family in safely turning defensiveness into openness.

MNTL-FI FEELING IDENTIFICATION

OUTCOME: The patient/family will understand the emotional/feeling states and reactions.

STANDARDS:

1. Assist in identifying the current emotional state, which may include a feelings chart or equivalent.
2. Discuss the strategies for improving emotional awareness and feeling identification, including writing exercises or feelings journals.

MNTL-GP GRIEVING PROCESS

OUTCOME: The patient/family will understand the grieving process as it relates to the specific issue or problem.

STANDARDS:

1. Explore any feelings of loss that affect the patient and the patient's loved ones.
2. Discuss the importance of keeping open communication and promoting social interaction in preserving the dignity of the patient.
3. Explore how separation and mourning are aspects of the bereavement process.
4. Explain that the need to repeatedly verbalize feelings is a normal part of grieving.

MNTL-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

MNTL-L LITERATURE

OUTCOME: The patient/family will receive literature about the topic or condition under consideration.

STANDARDS:

1. Provide the patient/family with literature on the topic or condition under consideration.
2. Discuss the content of the literature.

MNTL-PA PARENTING

OUTCOME: The patient/family will understand the parenting skills appropriate to meeting the needs of the child(ren).

STANDARDS:

1. Discuss the methods for appropriate parenting at home, including the appropriate use of rewards and consequences, and methods for improving the adult-child relationship.
2. Discuss the physical, emotional, and cognitive needs of the child based on age and level of development.

3. Emphasize the importance communicating in a way that the child understands.
4. Discuss the methods for providing emotional support and unconditional assistance to the child.
5. Refer the family to mental health services/family counseling if the family/child(ren) are becoming overwhelmed.

MNTL-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of the patient's mental health condition.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

MNTL-REL INTERPERSONAL RELATIONSHIPS

OUTCOME: The patient/family will understand the differences between healthy and unhealthy relationships.

STANDARDS:

1. Discuss the elements of healthy relationships and methods for building them, including:
 - a. Mutual respect
 - b. Safety/Security
 - c. Trust
 - d. Honesty
 - e. Vulnerability/Intimacy
 - f. Support/Caring
 - g. Fairness/Equality
 - h. Self-care/Privacy
 - i. Separate identities, and maintenance of friends and family

- j. Good communication
- k. Fair fighting techniques
- l. A sense of playfulness/fondness
2. Discuss the elements of unhealthy relationships and how to avoid them or resolve the problems, including:
 - a. Domestic violence/lack of safety
 - b. Unilateral decisions
 - c. Putting one's needs before the other
 - d. One partner controlling the resources
 - e. Pressuring one's partner into agreeing with one
 - f. Lack of privacy/monitoring partner's time, space, cell phone, mileage, etc.
 - g. Have no common friends or lack a respect for partner's friends and families
 - h. Do not prioritize quality time together
 - i. Experience lack of fairness or equality
 - j. Enmeshment/Lack of social network outside the relationship
3. Discuss the reasons that one remains in an unhealthy relationship, even when one has decided to leave. Address these issues, including fear of being alone, shame, insecurities/feelings of worthlessness, financial reasons, etc.

MNTL-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in coping with the particular problem or issue.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in coping with the particular problem or issue.
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.

MR - Mental Retardation

MR-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to mental retardation.

STANDARDS:

1. Discuss the common difficulty for families coping with the impact of a family member being diagnosed with Mental Retardation as a life-long illness that requires a change in lifestyle for the caretakers (**refer to [“MR-LA Lifestyle Adaptations”](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common for families who learn about their relative’s diagnosis.
3. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness (**refer to [“MR-C Complications”](#)**).
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Refer to a mental health agency or provider.

MR-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications associated with mental retardation.

STANDARDS:

1. Explain that the lack of communication skills may predispose the individual to emotional instability (e.g. lability of mood) or behavioral dyscontrol (e.g. aggressiveness), and may develop into other co-morbid conditions, such as depressive disorders (**refer to [“DEP - Depressive Disorders”](#)**) and Impulse Control Disorders (**refer to [“IMPLS - Impulse Control Disorders”](#)**).
2. Explain that individuals diagnosed with Mental Retardation are often vulnerable to exploitation or abuse.
3. Discuss possible psychosocial complications, including inability to care for self, inability to interact with others appropriately, and social isolation.

MR-CM CASE MANAGEMENT

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

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, school, teachers, 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”](#).**

MR-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 health and wellness.

STANDARDS:

1. Explain that the current standardized tests of aptitude and adaptive functioning scales do not accurately reflect the Native American population in their standardization sample, and may therefore reflect inaccurate scores.
2. Discuss the efforts made to ensure that interpretation of intelligence test procedures and scores reflect adequate attention to the individual's ethnic or cultural background.
3. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
4. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

MR-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms, course, and causes of mental retardation.

STANDARDS:

1. Explain the criteria for the diagnosis of Mental Retardation:
 - a. Significantly sub-average intellectual functioning as scored on standardized intelligence tests (IQ tests).
 - b. Concurrent deficits or impairments in present adaptive functioning, i.e., the person's effectiveness in meeting standards expected for the person's age and cultural group.

- c. Explain the degree of severity reflecting the level of intellectual impairment:
2. Explain that the age of onset must be before 18 years old, and the course of the mental retardation is influenced by the course of the underlying general medical conditions or by environmental factors at the root of Mental Retardation:
3. Explain that mental retardation is not necessarily a lifelong disorder, and that individuals with a mild severity may develop good adaptive skills and no longer have the level of impairment required for a formal diagnosis.
4. Explain that some individuals are passive, placid, and dependent, while others are aggressive and impulsive.
5. Discuss the causes or potential causes of the mental retardation, including hereditary/genetic, prenatal causes, childhood illness, and environmental causes.
6. Discuss the prognosis for the individual, which may vary according to the cause and severity of the mental retardation

MR-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in maintaining health and wellness.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

MR-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of complications associated with mental retardation.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

MR-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding mental retardation.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding mental retardation and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

MR-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

MR-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to mental retardation.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.

- a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
 3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
 4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
 5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

MR-L LITERATURE

OUTCOME: The patient/family will receive literature about mental retardation.

STANDARDS:

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

MR-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for compensating to impairment in functioning, or coping with the family member's limitations.

STANDARDS:

1. Discuss that the family may also require lifestyle adaptations to care for the patient, including the skills needed for special needs.
2. Discuss ways to optimize quality of life.
3. Refer to community services, resources, or support groups, as available.

MR-M MEDICATIONS

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

STANDARDS:

1. Explain the usefulness of medications in alleviating symptoms of associated disorders or features, such as depression (**refer to [“DEP-M Medications”](#)**) or aggressive behavior.
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 full participation with the medication plan and that this is the patient’s responsibility. Discuss any barriers to full participation.
6. 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.

MR-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for mental retardation.

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.

MR-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to mental retardation.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

MR-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment

- e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

MR-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to the adaptive functioning of the individual with mental retardation, and the risk of harm to self or others.

STANDARDS:

1. Discuss the potential consequences of the individual's limitations in self-care, problem solving, conflict resolution, and impulse control.
2. Discuss the importance of providing a safe environment, as appropriate. **Refer to [“CHT-S Safety”](#).**
3. Discuss/review the safety plan with the patient and family, including emergency procedures should the individual decompensate in terms of emotional stability and behavioral control.
4. Review the local resources and phone numbers, including the police, who may be utilized during a crisis, and may assist in transportation and safety compliance.

MR-SCR SCREENING

OUTCOME: The patient/family will understand the proposed screening including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed screening.
2. Explain the process and what to expect after the screening.
3. Emphasize the importance of follow-up care.

MR-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in coping with emotional instability and behavioral problems associated with mental retardation.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in coping with emotional instability and behavioral problems associated with mental retardation.
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.

MR-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential limitations, the expected benefits, and the problems with non-testing in regards to mental retardation.

STANDARDS:

1. Explain test(s) that have been ordered, including Intelligence Tests (IQ Tests) and adaptive functioning scales:
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. interpretation of test results with cultural, social, and spiritual variables factored in
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

MR-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

MR-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 participation in the treatment plan.
 - a. Explain that the primary goal of treatment is to develop the person's potential to the fullest, and includes social skills to help the person function as normally as possible.
 - b. Explain that some forms of Mental Retardation are treatable medically, such as those caused by hypothyroidism.
 - c. Explain that special education and training may begin as early as infancy.
 - d. Explain that behavioral approaches are important for people with mental retardation. No treatment exists to improve intellectual ability.
 - e. Explain that older individuals may learn independent living and job skills, which depends on the degree of impairment.
2. Explain that separate treatment will be necessary for co-morbid conditions, such as depression or aggressive behavior, and may include psychopharmacological intervention.

MSX - Metabolic Syndrome

MSX-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

MSX-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components as it relates to metabolic syndrome.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with metabolic syndrome as a life-altering illness that requires a change in lifestyle (refer to [“MSX-LA Lifestyle Adaptations”](#)).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with metabolic syndrome, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. Refer to [“AOD - Alcohol and Other Drugs”](#).
6. Refer to a mental health agency or provider.

MSX-C COMPLICATIONS

OUTCOME: The patient/family 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 good control of blood glucose and weight loss can reverse or prevent progression of pre-diabetes.
3. Explain that arteriosclerosis and atherosclerosis impede blood flow through the circulatory system. Discuss the following as appropriate:
 - a. Heart attacks may result from the heart having to work harder to pump blood through congested and hardened arteries.
 - b. Strokes may result due to injured blood vessels in the neck or brain.
 - c. Blindness may result from injured blood vessels in the eye.
 - d. 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 metabolic control.

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.”](#)**

MSX-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

MSX-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology of the metabolic syndrome.

STANDARDS:

1. Explain that metabolic syndrome is a combination of increase in abdominal fat, dyslipidemia, hypertension and pre-diabetes (insulin resistance).
2. Review the risk factors and causative factors of increase in abdominal fat, 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.
6. Discuss the role of abdominal fat, waist circumference, or BMI. Define normal ranges.

MSX-EQ EQUIPMENT

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

STANDARDS:

1. Provide the patient with information on the use of specific home blood pressure and blood sugar 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, blood sugar, 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/family will understand the of exercise and weight loss to achieve metabolic control. 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding metabolic syndrome.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding metabolic syndrome and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

MSX-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.

2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes

MSX-L LITERATURE

OUTCOME: The patient/family 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/family 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, a healthy weight, and regular physical activity are the critical components in gaining metabolic control and preventing the progression to diabetes and cardiovascular disease.
2. Explain that while medications may help, lifestyle adaptations are the key to improving health.
3. Discuss the importance of tobacco cessation. Make referral to tobacco cessation programs if available.
4. Discuss the relationship of stress to metabolic syndrome and suggest ways to reduce stress. Refer to stress reduction program as appropriate.
5. Assist the patient/family 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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/family to bring this list and pill bottles to appointments for medication reconciliation.

MSX-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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 (eat fewer calories, eat less saturated fats, eat more whole grains, fruits and vegetables, eat more fish, use healthier fats, avoid trans fats), appropriate serving sizes, and food preparation. Refer to registered dietitian for MNT as appropriate.
2. 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
3. Explain that reducing consumption of alcohol in conjunction to diet modifications can reduce triglycerides.
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.
3. Explain that the metabolic syndrome tends to run in families and that the patient's family members should be evaluated by a physician or other healthcare provider.
4. Explain that breastfeeding for 6 months to a year can decrease the risk of diabetes for mother and infant. Explain that child bearing can lead to the development of metabolic syndrome and that part of the association may be through weight gain and lack of exercise.

MSX-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Explain that breastfeeding for 6 months to a year can decrease the risk of diabetes for mother and infant. Explain that child bearing can lead to the development of metabolic syndrome and that part of the association may be through weight gain and lack of exercise.
4. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
5. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
6. Refer for medical and psychosocial support services for any risk factor identified.

MSX-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. Refer to [“AF-REF Referral Process”](#).
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

MSX-SCR SCREENING

OUTCOME: The patient/family will understand the proposed screening including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed screening, e.g., blood sugar, blood pressure, physical activity, BMI or waist circumference.
2. Explain the process and what to expect after the screening.
3. Emphasize the importance of follow-up care.

MSX-SM STRESS MANAGEMENT

OUTCOME: The patient/family 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/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

MSX-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

MSX-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

MDRO - Multidrug-resistant Organism

MDRO-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and important complications associated with multidrug-resistant organism infections (MDRO)

STANDARDS:

1. Review the symptoms of a generalized infection, e.g., high fever, changes in mental status, decreased urine output.
2. As appropriate, review the effects of uncontrolled or generalized infection, e.g., loss of limb, multi-organ failure, death.
3. Emphasize the importance of early treatment to prevent complications.

MDRO-CM CASE MANAGEMENT

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

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”](#).**

MDRO-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

MDRO-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the causes and impact of MDRO infections on health and wellness.

STANDARDS:

1. Explain that most infections are controlled by the body's defense mechanisms. However, some infectious agents cannot be controlled by the body's defenses and require antibiotics.
2. Explain that antibiotic resistance occurs:
 - a. when bacteria change their structure and/or DNA so antibiotics no longer work.
 - b. frequently when antibiotics are used for conditions where they are not needed (e.g. colds)
 - c. when antibiotics are not taken for a complete treatment course (e.g. stopped before end of treatment)
 - d. when antibiotics are shared or saved for later use without input from a healthcare provider
3. Discuss that some bacteria have developed ways to survive antibiotics that are meant to kill them. Some bacteria have become resistant to multiple antibiotics and require special antibiotic treatments. These are referred to as Multi Drug Resistant Organisms or MDROs. Common ones are:
 - a. Methicillin resistant Staphylococcus aureus (MRSA)
 - b. Vancomycin-resistant Enterococcus (VRE)
 - c. Multi-Drug Resistant Tuberculosis (MDRTB)
4. Discuss the meaning and impact of colonization.

MDRO-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction

- f. Infection control principles, including proper disposal of associated medical supplies
- g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

MDRO-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

MDRO-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of the specific MDRO infection.

STANDARDS:

1. Explain the home management techniques necessary based on the status of the patient. Explain that these home management techniques may change on a day-to-day or week-to-week basis.
2. Discuss the importance and implementation of hygiene and infection control measures in the home, including sanitation (specific cleansers), personal protective equipment, and isolation.
3. Refer to community resources, as appropriate.

MDRO-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

MDRO-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene in preventing and controlling the spread of MDRO infection.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

MDRO-ISO ISOLATION

OUTCOME: The patient/family will understand healthcare services and resources available as it relates to insurance and benefits.

STANDARDS:

1. Explain that isolation of the patient prevents the spread of the MDRO infection to healthcare providers, other patients, and family members.
2. Explain the type of isolation being implemented and associated precautions, protective equipment to be used:
 - a. Respiratory isolation
 - b. Contact precaution

MDRO-L LITERATURE

OUTCOME: The patient/family will receive literature about MDRO infection.

STANDARDS:

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

MDRO-M MEDICATIONS

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

STANDARDS:

1. Emphasize the importance of strictly adhering to the medication regimen and taking the entire course of prescribed medication. Discuss the need for possible directly-observed therapy, and the consequences of not completing the agreed-upon treatment. **Refer to [“TB-DOT Directly Observed 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.
4. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
5. Discuss the importance of full participation with the medication plan and that this is the patient’s responsibility. Discuss any barriers to full participation.
6. 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.

MDRO-P PREVENTION

OUTCOME: The patient/family will understand the appropriate measures to prevent this MDRO infection or the spread of this infection.

STANDARDS:

1. Emphasize that the appropriate use of antibiotics can reduce the likelihood of the development of MDROs.
2. Discuss the importance of and the procedure for hand hygiene and/or respiratory precautions in preventing the spread of this MDRO infection.
3. Discuss the importance of and procedure for contact precautions in preventing the spread of this MDRO infection, such as:
 - a. Discuss wearing appropriate protective equipment (e.g., proper footwear, long sleeves, long pants, gloves) in preventing skin injuries that provide a portal for infection.
 - a. If participating in contact sports where there is skin to skin contact, stress the importance of showering immediately after the activity and not sharing personal items such as towels or razors. Stress the importance of frequently sanitizing surfaces that come into frequent contact with bare skin, e.g. exercise equipment, counter tops, toys, door knobs, telephones. Explain the importance of keeping skin abrasions or cuts covered with clean, dry bandages.
4. Review the importance of maintaining good general health and controlling chronic medical conditions, e.g. glycemic control in diabetes.
5. Explain that limiting exposure to healthcare settings may reduce the risk of acquiring a MDRO.

MDRO-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.

4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

MDRO-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

MDRO-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.

3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

MDRO-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

MD - Muscular Dystrophy

MD-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family 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 many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is able to provide guidance at the time that decisions need to be made.
3. Explain that the Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences of care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.

MD-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

MD-C COMPLICATIONS

OUTCOME: The patient/family will understand the common complications of muscular dystrophy.

STANDARDS:

1. Discuss common complications of muscular dystrophy: cardiomyopathy, decreased ability to care for self, decreased mobility, joint contractures, mental impairment, respiratory failure, and scoliosis.
2. Describe the signs/symptoms of common complications of muscular dystrophy, such as lost ability to walk, to sit upright, to breathe easily, to move the arms and hands.

MD-CM CASE MANAGEMENT

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

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”](#).**

MD-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

MD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand that muscular dystrophy is a group of disorders that involve muscle weakness and loss of muscle tissue that get worse over time. There are no known cures.

STANDARDS:

1. Discuss that muscular dystrophy is caused by incorrect or missing genetic information that prevents the body from making the proteins needed to build and maintain healthy muscles.
2. Explain that muscular dystrophy is a genetic disorder that gradually weakens the body's muscles. Specific muscle groups are affected by different types of muscular dystrophy and signs include: curved spine, joint contractures, low muscle tone, and disturbed heart rhythm.
3. Explain that there is no cure for muscular dystrophy, but researchers are quickly learning more about how to prevent, treat, and slow progression.
4. Some types of muscular dystrophy are deadly. Other types cause little disability and people with them have a normal lifespan.

MD-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

MD-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.

2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

MD-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

MD-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding muscular dystrophy.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding muscular dystrophy and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

MD-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of muscular dystrophy.

STANDARDS:

1. Explain the home management techniques, such as remodeling a home related to stairs, wheelchair accessibility to shower/bathroom, bedroom, living room, dining area, and vehicle.
2. Discuss the implementation of hygiene and infection control measures.

3. Refer to community resources, hospice, or support groups, as appropriate.

MD-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

MD-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to muscular dystrophy.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.

4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

MD-L LITERATURE

OUTCOME: The patient/family will receive literature about muscular dystrophy.

STANDARDS:

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

MD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for muscular dystrophy.

STANDARDS:

1. Discuss lifestyle adaptations specific to muscular dystrophy.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

MD-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

MD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for muscular dystrophy.

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.

MD-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to muscular dystrophy.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

MD-P PREVENTION

OUTCOME: The patient/family will understand that genetic counseling is advised when there is a family history of muscular dystrophy.

STANDARDS:

1. Discuss that women may have no symptoms but still carry the gene for the disorder.
2. Explain that Duchenne muscular dystrophy can be accurately detected by genetic studies performed during pregnancy. **Refer to [“FP-ST Sterilization”](#).**

MD-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

MD-PRO PROCEDURE

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 of 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 for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

MD-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of muscular dystrophy.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

MD-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to muscular dystrophy.

STANDARDS:

1. Discuss muscle weakness and frequent falls.
2. Explain the important of home safety.

MD-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in muscular dystrophy.
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.

MD-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

MD-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

MD-TX TREATMENT

OUTCOME: The patient/family will understand the treatment plan, and the goal of treatment is to control symptoms.

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

MD-WC WOUND CARE

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

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, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
3. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
4. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
5. Discuss any special recommendations or instructions particular to the patient's wound.

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-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to near drowning.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with near drowning, as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with near drowning, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.

5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).**
6. Refer to a mental health agency or provider.

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.
3. Explain the danger of developing mental health diagnoses as a result of near drowning, including a water phobia (**refer to [“PHOB - Phobias](#)**) and Posttraumatic Stress Disorder (**refer to [“PTSD - Posttraumatic Stress Disorder](#)**).

NDR-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-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.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

NDR-P PREVENTION

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

STANDARDS:

1. Explain that the key to the prevention of drowning is education regarding safety around water. This includes the following elements:
 - a. Parents should be aware of their own as well as their children's limitations around water. Children must be supervised when near water even if not swimming.
 - b. Never swim alone and always supervise children when swimming.
 - c. Safe conduct around water and during boating and water or jet skiing is extremely important.
 - d. The use of alcohol or recreational drugs while around water is a common factor in water-related accidents.
 - e. The use of appropriate boating equipment, (personal flotation devices) is important.
 - f. Awareness of weather and water conditions prior to boating or swimming may prevent being stranded in water during a storm.
 - g. Check water depth and underwater hazards (e.g., rocks, drop-offs, currents) prior to swimming and diving.
 - h. Provide fencing and locking gates around swimming pools.
2. 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
3. Encourage patient/family members to learn CPR and rescue techniques.

NDR-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)

- e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
- a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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 understand and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction

- f. Infection control principles, including proper disposal of associated medical supplies
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

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 the 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, 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 patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed

- c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
- a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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 neonatal jaundice:
 - a. Occurs in more than 50% of newborns
 - b. Is characterized by yellow discoloration of the skin and in some cases the whites of the eyes.
 - c. Is caused by a chemical in the blood called bilirubin which is a breakdown product of red blood cells.
2. 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.
3. 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
4. Explain, as appropriate, that some individuals are at higher risk for developing 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-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to the specific neurological disorder.

STANDARDS:

1. Explain the normal anatomy and physiology of the nervous system as it relates to this specific disorder.
2. Discuss the changes to anatomy and physiology as a result of this neurological disorder.
3. Discuss the impact of these changes on the patient's health or well-being.

ND-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to the specific neurological disorder.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with the specific neurological disorder as a life-altering illness that requires a change in lifestyle (**refer to [“ND-LA Lifestyle Adaptations](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with the specific neurological disorder, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#)**.
6. Refer to a mental health agency or provider.

ND-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

ND-DP DISEASE PROCESS

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

ND-L LITERATURE

OUTCOME: The patient/family will receive literature about the neurological disorder.

STANDARDS:

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

ND-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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

ND-MNT MEDICAL NUTRITION THERAPY

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

ND-N NUTRITION

OUTCOME: The patient/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 its use in developing a plan to manage pain.
2. Explain that pain management is specific to the disease process and the patient; and may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
5. Explain non-pharmacologic measures that may be helpful with pain control.
6. Explain that all chest pain must be evaluated by the medical provider to rule out the possibility of myocardial infarction.

ND-S SAFETY

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, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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.

NOSE - Nose Bleed (Epistaxis)

NOSE-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology of the nasal passage and how it relates to nose bleeds.

STANDARDS:

1. Explain that the inside of the nose is covered with mucosa that has a rich blood supply. This warms and moistens the air we breathe as it travels through the nostrils to the lungs. A thin flexible wall called a septum separates the two nostrils.
2. Discuss how damaged or injured blood vessels inside the nose can cause nose bleeds.
3. Explain that nose bleeds can happen in the anterior (front) or posterior (back) part of the nose.

NOSE-C COMPLICATIONS

OUTCOME: The patient will understand the complications of nose bleeds.

STANDARDS:

1. Discuss the common or significant complications associated with nose bleeds (e.g., infection, blood loss, vomiting).
2. Discuss how these complications may be prevented by proper treatment.
3. Discuss common or significant complications that may result from treatment.

NOSE-DP DISEASE PROCESS

OUTCOME: The patient/family will understand general information about nose bleeds.

STANDARDS:

1. Discuss how the following may cause or increase the risks of having a nose bleed:
 - a. Trauma (directly breaks blood vessels)
 - b. Extreme temperatures (hot, cold, dry)
 - c. Inflammation (widens blood vessels)
 - d. Medicines (dries/thins nasal mucosa, vasodilates blood vessels, thins blood)
 - e. Heavy alcohol, smoking, or illegal drug use (thins nasal lining)
 - f. Others (high blood pressure, bleeding problems, abnormal blood vessels in the nose, and tumors)

2. Discuss that symptoms of nose bleeds may include, dark or bright red blood from the nose, trouble breathing, smelling, or talking (if blood clots block the nostrils). Posterior nose bleeds may present as coffee ground emesis or black & tarry stools.
3. Explain that nose bleeds are the result of blood vessels in the nose breaking.
4. Explain that nose bleeds are usually self limiting. Prompt treatment is needed for prolonged bleeding.

NOSE-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

NOSE-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of nose bleeds.

STANDARDS:

1. Explain that nose bleeds are usually self-limiting and can often be treated at home using first aid techniques.
2. Explain and demonstrate first aid for nose bleeds.
 - a. Lean forward to keep blood from going down the back of the throat, and breathe through the mouth.
 - b. Pinch the lower soft part of the nose tightly.
 - c. While pinching the nose, apply ice to the bridge of the nose to slow down the bleeding.
 - d. After pinching the nose for 5 minutes, release to check for bleeding. If the bleeding continues, repeat pinching and icing for up to 20 minutes.
 - e. Seek medical help if:
 - i. Bleeding cannot be stopped or keeps reappearing.
 - ii. Bleeding is rapid or if blood loss is large.

- iii. Feeling weak or faint, presumably from blood loss.
- iv. Taking medications (such as warfarin) for blood thinning.
- v. Bleeding begins by going down the back of the throat rather than the front of the nose.

NOSE-HY HYGIENE

OUTCOME: The patient/family will understand hygiene as it relates to nose bleeds.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Discourage nose picking or inserting other objects into the nose.
6. Discuss the disposal of bloody tissues.

NOSE-L LITERATURE

OUTCOME: The patient/family will receive literature about nose bleeds.

STANDARDS:

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

NOSE-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

NOSE-P PREVENTION

OUTCOME: The patient/family will understand ways of preventing nose bleeds.

STANDARDS:

1. Discuss how prevention strategies for nose bleeds are directly related to causative factors.
2. Review the following ways of preventing nose bleeds as applicable:
 - a. Protect the nose from injury by not picking the nose, wearing helmets while playing sports, avoiding fist fights.
 - b. Keep the nasal passage moist with the use of saline nose drops/spray or other lubricants. Use of a humidifier in the home may also reduce nasal dryness.
 - c. For environmental allergies, take allergy medicine as prescribed. These medicines will help prevent inflammation in the nasal cavity.
 - d. Review medication list for medications that cause anti-cholinergic (drying) side effects. Dose reductions or medication changes may be warranted.
 - e. Quitting or reducing alcohol, smoking, or illegal drug use.
 - f. Management of other conditions that may increase the chance of nose bleeds (hypertension, bleeding problems).

NOSE-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure for nose bleeds.

STANDARDS:

1. Discuss the indications, risks, and benefits of 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 for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections

NOSE-S SAFETY

OUTCOME: The patient will understand safety concerns related to nose bleeds.

STANDARDS:

1. Explain that blood can carry disease and should be handled with Standard Precautions.
2. Discuss the use of protective head gear in reducing injuries that cause nose bleeds.

NOSE-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results, as appropriate, such as the BMI, waist circumference, and other screening tests

- b. follow-up tests may be ordered based on the results
- c. how results will impact or effect the treatment plan
- d. recommendations based on the test results

NOSE-TX TREATMENT

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

STANDARDS:

1. Explain that the goal of treatment for nose bleeds is to control bleeding and to treat the underlying cause.
2. Explain and demonstrate first aid for nose bleeds.
 - a. Lean forward to keep blood from going down the back of the throat, and breathe through the mouth.
 - b. Pinch the lower soft part of the nose tightly.
 - c. While pinching the nose, apply ice to the bridge of the nose to slow down the bleeding.
 - d. After pinching the nose for 5 minutes, release to check for bleeding. If the bleeding continues, repeat pinching and icing for up to 20 minutes.
3. Explain that nose bleeds are usually self limiting, but prompt treatment is needed to prevent prolonged bleeding.
4. Discuss that different treatments are available for nose bleeds depending on the severity. These treatment options may include: vasoconstricting medicines, nasal packing, laser therapy, or surgery.
5. Review ways of preventing recurrence:
 - a. Do not pick or blow nose (sniffing is all right).
 - b. Do not strain or bend down to lift anything heavy.
 - c. Keep head higher than the level of the heart.

O**OBS - Obesity****OBS-BH BEHAVIORAL AND EMOTIONAL HEALTH**

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to obesity.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with obesity as a life-altering illness that requires a change in lifestyle (**refer to [“OBS-LA Lifestyle Adaptations](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with obesity, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#)**.
6. Refer to a mental health agency or provider.

OBS-C COMPLICATIONS

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

STANDARDS:

1. Emphasize that obesity is one of the most important risk factors in the onset of Diabetes Mellitus type 2 and can enhance complications.
2. Explain that obesity increases the risk for insulin resistance, glucose intolerance, cardiovascular disease, metabolic syndrome, hypertension, acanthosis nigricans, infertility, cholelithiasis, fatty liver, joint problems, sleep apnea, and certain types of cancers.
3. Explain that eating disorders can contribute to obesity or can be a complication of obesity.
4. Discuss psychosocial issues related to obesity such as decrease self-esteem, self-image, self-efficacy and isolation/depression.

OBS-CM CASE MANAGEMENT

OUTCOME: The patient/family will understand the importance of integrated case management for achieving and maintaining a healthy weight.

STANDARDS:

1. Discuss 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”](#).

OBS-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

OBS-DP DISEASE PROCESS

OUTCOME: The patient/family will understand obesity as a chronic disease.

STANDARDS:

1. Explain that genetics and environment can play a significant role in obesity.
2. Explain that a sedentary lifestyle and over nutrition has been implicated with obesity and chronic disease.
3. Explain that hypothalamic injury, endocrine disease, and long-term use of certain medications can contribute or enhance obesity.

OBS-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in achieving and maintaining a healthy body weight.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of physical activity, such as weight loss, increased energy, improvement in well being, stress reduction, improved sleep, bowel regulation, and improved self image.
3. Discuss barriers to a personal physical activity plan and solutions to overcome barriers. Assist the patient in developing a personal physical activity plan. **Refer to [“HPDP-EX Exercise.](#)**
4. Encourage the patient to increase the frequency, 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

OBS-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding obesity.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding obesity and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

OBS-IR INFORMATION AND REFERRAL

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

STANDARDS:

1. Provide the patient/family with alternative or additional sources for achieving personal healthcare goals.
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/family will understand the importance of lifestyle adaptations and behavior changes to achieve and maintain a healthy weight.

STANDARDS:

1. Review the intervention treatment plan with the patient/family.
2. Emphasize the importance of good hygiene because additional body fat increases perspiration.
3. Discuss the pros and cons of alternative weight loss options, e.g., caloric restriction diets, other diets, weight-loss surgery, medications, or herbal therapies/commercial supplements.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.

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.

OBS-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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, e.g., 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 issues.
5. Explain how reading food labels, including how to identify various ingredients on the labels, may be helpful in monitoring portion size and caloric intake.

OBS-P PREVENTION

OUTCOME: The patient/family will 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.”](#)**
3. **Refer to [“HPDP-N Nutrition](#) and [“OBS-C Complications.”](#)**
4. Identify cultural, familial, and personal perceptions of body image and their relationship to obesity and health.

OBS-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age

- c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

OBS-SCR SCREENING

OUTCOME: The patient/family will understand the proposed 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 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
6. Provide referrals as appropriate.

OBS-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

OBSC - Obesity in Children (Infancy to 18 Years)

OBSC-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to obesity in children aged infancy to 18 years.

STANDARDS:

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

OBSC-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to obesity.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with obesity as a life-altering illness that requires a change in lifestyle (**refer to ["OBSC-LA Lifestyle Adaptations"](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with obesity, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to ["AOD - Alcohol and Other Drugs"](#)**.
6. Refer to a mental health agency or provider.

OBSC-C COMPLICATIONS

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

STANDARDS:

1. Explain that obesity increases the risk for Diabetes Mellitus Type 2 and increases an earlier onset for diabetes complications.
2. Explain that obesity increases the risk for hypertension, cardiovascular disease, cholelithiasis, sleep apnea, hyperlipidemia, insulin resistance, glucose intolerance,

PATIENT EDUCATION PROTOCOLS:**OBESITY IN CHILDREN (INFANCY TO 18 YEARS)**

acanthosis nigricans, fatty liver, pseudotumor cerebri, orthopedic conditions, early maturation, and polycystic ovary disease.

3. Explain that obesity increases the risk of hip disorders (e.g., Slipped Capital Femoral Epiphysis (SCFE)) related to the shear force around the proximal growth plate at the hip.
4. Discuss the relationship of obesity to psychosocial issues such as decreased self-esteem, decreased self-image, bullying, and isolation/depression.
5. Explain that eating disorders can contribute to obesity or can be a complication of obesity.

OBSC-CM CASE MANAGEMENT

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

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”](#).**

OBSC-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 achieving and maintaining a healthy weight.

STANDARDS:

1. Discuss cultural norms/perceptions regarding weight and how that relates to a healthy weight. Discuss mechanisms for coping with family pressure to increase weight.
2. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, e.g., diet, physical activity, sleep, stress management, hygiene, full participation to the medical plan.
3. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining a healthy weight.
4. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are interactions with prescribed treatment.

OBSC-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the known causes of obesity.

STANDARDS:

1. Explain the relationship between increased caloric intake and decreased energy expenditure in relation to obesity.
2. Explain that genes and environment play a role in obesity. E.g., family and parental obesity.
3. Explain that a sedentary lifestyle has been related to obesity and chronic disease.
4. Explain that obesity can also be caused by hypothalamic injury and endocrine disease.
5. Explain the role of prenatal care and low birth weight in relation to obesity.

OBSC-EX EXERCISE

OUTCOME: The patient will understand the relationship of physical activity in achieving and maintaining a healthy body weight.

STANDARDS:

1. Discuss the benefits of physical activity, such as weight loss, improvement in well being, stress reduction, increased self-image, self-efficacy. Discuss that one hour of physical activity daily is beneficial in treating and preventing child obesity.
2. Discuss barriers to physical activity and solutions to overcome barriers. Assist the patient/family in developing a physical activity plan.
 - a. Discuss safe and recommended duration of exercise for the individual.
 - b. Discuss safe introduction and types of exercise for obese children.
3. Discuss the appropriate frequency, intensity, time, and type of activity.
4. Refer to community resources as appropriate.

OBSC-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.

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4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

OBSC-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding childhood obesity.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding childhood obesity and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

OBSC-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and maintain a healthy weight and prevent overweight and obesity.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, emotions, and spirit) and is a positive state which results from healthy choices.
2. Discuss that low self-esteem associated with obesity may lead to high-risk behaviors. Explain healthy lifestyle choices (e.g., spirituality, social connections, physical activity, nutrition) and avoidance of high-risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

OBSC-HY HYGIENE

OUTCOME: The patient/family will understand personal hygiene.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.

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- a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, skin folds, and feet. Discuss hygiene as part of a positive self image.
 3. Review the importance of good hygiene because additional body fat increases perspiration.
 4. Review the importance of daily dental hygiene, with attention to brushing and flossing. A freshly brushed mouth may act a deterrent to snacking.
 5. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
 6. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

OBSC-L LITERATURE

OUTCOME: The patient/family will receive literature about achieving and maintaining a healthy weight.

STANDARDS:

1. Provide the patient/family with literature on achieving and maintaining a healthy weight.
2. Discuss the content of the literature.

OBSC-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the importance of making lifestyle adaptations to achieve and maintain a healthy weight.

STANDARDS:

1. Discuss methods of increasing physical activity such as, walking, participating in sports, active play. Emphasize the importance of decreasing time spent watching TV, playing video game, and other sedentary activities. **Refer to [“OBSC-EX Exercise”](#).**
2. Encourage physical activities that the patient enjoys.
3. Discuss how to identify and avoid stimuli that trigger unhealthy eating or overeating. E.g., frequently eating fast foods, and unintentional eating while participating in sedentary activities.

OBSC-M MEDICATIONS

OUTCOME: The patient/family will understand the role of medications in weight loss and weight gain.

STANDARDS:

1. Explain that prescription medications are not routinely used for childhood obesity.
2. Discuss medications that can increase appetite or cause weight gain.

OBSC-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for the treatment or management of obesity in children and their families.

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.

OBSC-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition in achieving and maintaining a healthy weight.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, portion control, careful shopping, appropriate food preparation, and eating. Discuss strategies to assist the child in making healthy choices away from home (e.g., at school).
2. Emphasize food label reading.
3. Explain that six to eight small meals at frequent intervals is beneficial in reducing overeating.

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4. Explain that intake of sugar-sweetened beverages increases caloric intake. Explain that adequate water intake is necessary in achieving and maintaining a healthy weight.
5. Discuss the growth and development for appropriate age group, and the contraindications of fad diets. Refer to registered dietitian for weight management.

OBSC-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of developing obesity in children.

STANDARDS:

1. Discuss obesity in children.
2. Explain that healthy eating and exercise may help reduce the risk of developing obesity in children. **Refer to ["OBSC-EX Exercise"](#) and ["OBSC-N Nutrition"](#).**

OBSC-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in obesity.

STANDARDS:

1. Explain that overeating can be a coping mechanism to deal with stress.
2. Explain that stress is related to decreased energy and can compromise physical activity.
3. Explain that being overweight can cause emotional and physical stress.

OBSC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test

PATIENT EDUCATION PROTOCOLS:**OBESITY IN CHILDREN (INFANCY TO 18 YEARS)**

2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

OBSC-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

OCD - Obsessive-Compulsive Disorder

OCD-C COMPLICATIONS

OUTCOME: The patient/family will understand some of the complications associated with obsessive-compulsive disorder.

STANDARDS:

1. Explain that individuals diagnosed with obsessive-compulsive disorder often develop guilt feelings, a pathological sense of responsibility, and sleep disturbances.
2. Explain that obsessive intrusions can be distracting, and interfere with attention, memory, and learning.
3. Explain that hypochondriacal concerns are common in individuals diagnosed with OCD, which includes repeated visits to physicians to seek assurance.
4. Explain that obsessive-compulsive disorder may be associated with depression (refer to [“DEP - Depressive Disorders”](#)), other anxiety disorders (e.g., specific phobia/social phobia, (refer to [“PHOB - Phobias”](#)) and substance-related disorders (refer to [“AOD - Alcohol and Other Drugs”](#)) as a consequence of self-medicating the anxiety. Also, there is an especially high incidence of OCD in patients also diagnosed with Tourette’s disorder (refer to [“TICD - Tic Disorders”](#)).

OCD-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in obsessive-compulsive disorder.

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”](#).

OCD-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the treatment plan must be followed as prescribed to be effective.

OCD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of obsessive-compulsive disorder.

STANDARDS:

1. Explain that the essential features of obsessive-compulsive disorder include:
 - a. **Obsessions** are defined by:
 - i. Recurrent and persistent thoughts, impulses, or images usually about:
 - (1) contamination (e.g., by shaking hands)
 - (2) repeated doubts (e.g., wondering whether one has left the door unlocked)
 - (3) a need to have things in a particular order
 - (4) aggressive or horrific impulses (e.g., to hurt one's child)
 - (5) sexual imagery (e.g., repeated pornographic images)
 - ii. Obsessions are experienced as intrusive and inappropriate, are not simply worries, and cause marked anxiety or distress.
 - iii. The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.
 - iv. The person recognizes that the obsessions are a product of one's own mind, and are not the kind of thoughts that one would expect to have (although children are not expected to make this judgment).
 - b. **Compulsions** are defined by:
 - i. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
 - ii. The behaviors and mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation, but they are clearly excessive and are not connected in a realistic way with what they are designed to neutralize or prevent.

2. Explain that obsessions are not simply worries about real life problems, such as financial problems, and are unlikely to be related to real life problems. An individual's insight about the reasonableness of the obsessions and compulsions may vary across times and situations.
3. Explain that the obsessions and compulsions cause marked distress, are time consuming (more than 1 hour a day), or significantly interfere with the person's normal routine, occupational/ academic functioning, or usual social activities or relationships.
4. Explain that the disturbance is not due to the effects of a substance.

OCD-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 role that exercise will have in raising body awareness, and thereby improve one's ability to manage the OCD symptoms more effectively.
3. Discuss the other benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
4. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
5. Encourage the patient to increase the intensity and duration of the activity when becoming more fit.
6. Refer to community resources as appropriate.

OCD-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

OCD-HY HYGIENE

OUTCOME: The patient/family will understand the realistic versus unrealistic hygiene procedures as it relates to obsessive-compulsive disorder.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Review examples of unrealistic or excessive hygienic practices that may be unhealthy or impractical.
2. Review the importance of appropriate bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

OCD-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.

OCD-L LITERATURE

OUTCOME: The patient/family will receive literature about obsessive-compulsive disorder.

STANDARDS:

1. Provide the patient/family with literature on obsessive-compulsive disorder.
2. Discuss the content of the literature.

OCD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for obsessive-compulsive disorder.

STANDARDS:

1. Discuss lifestyle adaptations specific to obsessive-compulsive disorder:
 - a. Take medications as prescribed, even when feeling better and feel a desire to skip doses.
 - b. Learn and keep track of the warning signs of OCD to uncover potential triggers of anxieties related to obsessions and compulsions.
 - c. Avoid illicit drugs and alcohol.
 - d. Stay focused on goals and remember that recovery from OCD is an on-going process that requires constant motivation.
 - e. Explore healthy ways to channel energy, such as hobbies, exercise, and recreational activities.
 - f. Learn relaxation and stress management techniques (**refer to [“OCD-SM Stress Management”](#)**).
 - g. Learn to structure time and get organized.
2. Discuss that family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

OCD-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 full participation with the medication plan and that this is the patient’s responsibility. Discuss any barriers to full participation.
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.

OCD-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of obsessive-compulsive disorder.

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 classes, talking circles, or other modalities.
3. Emphasize that full participation and follow-up is critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain that the therapist and the patient will establish goals and duration of therapy together.

OCD-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to obsessive-compulsive disorder.

STANDARDS:

1. Discuss/review the safety plan and/or administrative treatment plan with the patient and family, including the no-harm contract and emergency procedures.
2. Review the local resources and phone numbers, including the police that may be utilized during a crisis, and may assist in transportation and safety compliance.

OCD-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in treating obsessive-compulsive disorder.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in obsessive-compulsive disorder.
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.

OCD-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

OCD-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options for obsessive-compulsive disorder.

STANDARDS:

1. Explain that a combination of psychotherapy and medication interventions usually has better results than therapy or medication alone. The patient has a right to choose either option or both, and that the patient's active participation in the treatment decisions is critical to a good outcome.

2. Explain that therapists have different styles and orientations of therapy, and that no one approach has been shown to be more effective than others, although some styles may suit the patient better.
3. Explain that medication intervention is the crucial factor for maintaining stability in OCD. Explain that decisions about timing and duration of medication will be made jointly by the provider(s) and the patient.
4. Explain that medication and psychotherapy may also be useful in treating comorbid conditions that exacerbate the course of OCD, and may help improve quality of life.
5. Explain that medication and psychotherapy may also be useful in treating comorbid conditions that exacerbate the course of OCD, and may help improve quality of life.

OSA - Obstructive Sleep Apnea

OSA-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of oropharynx and respiratory system.
2. Discuss the changes to anatomy and physiology resulting in obstructive sleep apnea.
3. Discuss the impact of these changes on the patient's health or well-being.

OSA-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of obstructive sleep apnea.

STANDARDS:

1. Explain that obstructive sleep apnea is considered a serious medical condition and if left untreated, can increase the risk of high blood pressure, heart failure, heart attack, and stroke.
2. Explain that early diagnosis and treatment of sleep apnea can reduce the incidence of severe complications.

OSA-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of obstructive sleep apnea.

STANDARDS:

1. Explain that sleep apnea is a breathing disorder in which there is a break or pause in breathing or reduction of airflow during sleep. Such apneas may occur hundreds of times every night.
2. Explain that obstructive sleep apnea is usually caused by abnormalities in the anatomy and muscle control of the pharyngeal airway. The recurrent obstruction causes loud snoring, brief awakenings, and a rise in blood pressure.
3. Discuss the common symptoms of sleep apnea:
 - a. Waking up with a very sore and/or dry throat
 - b. Waking up with a choking or gasping sensation
 - c. Sleepiness during the day

- d. Morning headaches
- e. Loud snoring

OSA-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
 - g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

OSA-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

OSA-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding OSA.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding OSA and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

OSA-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy
 - b. Be willing to change
 - c. Set small, realistic, sustainable goals
 - d. Practice new knowledge
 - e. Get help when necessary
4. Review the community resources available for help in achieving behavior changes.

OSA-L LITERATURE

OUTCOME: The patient/family will receive literature about obstructive sleep apnea.

STANDARDS:

1. Provide the patient/family with literature on obstructive sleep apnea.
2. Discuss the content of the literature.

OSA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations that can improve obstructive sleep apnea and prevent complications.

STANDARDS:

1. Discuss individualized lifestyle adaptations specific to obstructive sleep apnea:
 - a. Weight loss
 - b. Alcohol reduction
 - c. Change in sleeping position (avoid sleeping on back)
 - d. Tobacco cessation
 - e. Avoid sleeping pills, narcotics, or barbiturates
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize the quality of life.
4. Refer to community services, resources, or support groups, as available.

OSA-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

OSA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for obstructive sleep apnea.

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.

OSA-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to obstructive sleep apnea.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Explain that a low-calorie meal plan is needed for weight loss to improve the sleep apnea.
4. Refer to registered dietitian for MNT or other local resources as appropriate.

OSA-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.

4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

OSA-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

OSA-TX TREATMENT

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

STANDARDS:

1. Explain that the causes of obstructive sleep apnea are variable and there is seldom one specific treatment that will cure the problem.
2. Explain that the treatment plan will be based on individual's medical history, symptoms, severity of the disorder, and the cause.

3. Discuss the recommended treatment. Emphasize the importance of active participation by the patient/family in the treatment plan.
4. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.

OCCU - Occupational Health

OCCU-EQ EQUIPMENT

OUTCOME: The employee will understand and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Types and features of the equipment
 - b. Proper function of the equipment
 - c. Signs of equipment malfunction and proper action in case of malfunction
 - d. Infection control principles, including proper disposal of associated medical supplies
 - e. The importance of not tampering with any medical device
 - f. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
2. Discuss the use of the equipment as related to the health of the employee.

OCCU-EX EXERCISE

OUTCOME: The employee will understand the role of physical activity in maintaining health.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

OCCU-FU FOLLOW-UP

OUTCOME: The employee will understand the importance of follow-up in the treatment of employment-related injuries/illnesses.

STANDARDS:

1. Emphasize the importance of follow-up care.

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

OCCU-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The employee will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
 - f. review the community resources available for help in achieving behavior changes

OCCU-HY HYGIENE

OUTCOME: The employee will understand personal routine hygiene as it relates to the work environment.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.

2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

OCCU-IM IMMUNIZATIONS

OUTCOME: The employee will understand the immunizations necessary for preventing communicable diseases. **Refer to ["IM - Immunizations"](#).**

STANDARDS:

1. Discuss the illness that the recommended immunization prevents.
2. Discuss the side effects and potential adverse reactions that are common to this immunization.
3. Discuss the local policy concerning refusal. Discuss any alternatives to the immunization.

OCCU-L LITERATURE

OUTCOME: The employee will receive literature about the specific occupational health issue.

STANDARDS:

1. Provide the patient/family with literature on the specific occupational health issue.
2. Discuss the content of the literature.

OCCU-LA LIFESTYLE ADAPTATIONS

OUTCOME: The employee will understand lifestyle adaptations necessary for maintaining adequate health to maintain employment.

STANDARDS:

1. Discuss lifestyle adaptations specific to illness/injury and how they relate to employment.
2. Discuss that the family may also require lifestyle adaptations to assist the employee so employment can be maintained.
3. Discuss ways to optimize the quality of life.

4. Refer to community services, resources, or support groups, as available.

OCCU-M MEDICATIONS

OUTCOME: The employee 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

OCCU-OR ORIENTATION

OUTCOME: The new employee will understand measures that are necessary for employees to prevent the spread of infections.

STANDARDS:

1. Discuss the circumstances when screens will be conducted for infections or other risks when employees may have been exposed.
2. Describe symptoms of personal illness that should be reported to the supervisor/ Occupational Health Nurse according to the facility policy. Explain when restrictions will be imposed from providing direct patient care and/or the employee will be required to remain away from the healthcare facility entirely.
3. Explain measures that may be required to evaluate employees and volunteers exposed to patients with infections and communicable diseases.
4. Explain that each new employee will meet with the Occupational Health Nurse for the following:
 - a. screening for communicable diseases, such as TB
 - b. evaluation of immunization status for designated infectious diseases
 - c. fit-testing and use of personal protective equipment

5. Explain that on-going education will be required regarding the prevention and control of infections and communicable diseases.

OCCU-P PREVENTION

OUTCOME: The employee will understand ways to reduce risk of acquiring an employment related injury or illness.

STANDARDS:

1. Discuss the activity that causes the employee to be at risk for acquiring an employment related injury or illness.
2. Explain ways to prevent the specific employment related injury or illness.

OCCU-PM PAIN MANAGEMENT

OUTCOME: The employee will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

OCCU-S SAFETY

OUTCOME: The employee will understand safety as it relates to the employee’s work.

STANDARDS:

1. Discuss specific hazards related to the employee’s specific assigned work.
2. Explain safety measures that are in place to prevent injuries and how these measures should be utilized.

OCCU-SCR SCREENING

OUTCOME: The employee will understand the proposed screening including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed screening, e.g., blood pressure, hearing, vision, development, mental health, TB.
2. Explain the process and what to expect after the screening.
3. Emphasize the importance of follow-up care.

OCCU-SM STRESS MANAGEMENT

OUTCOME: The employee will understand the role of stress management in maintaining health and optimal function at work.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management maintaining optimal function at work.
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.

OCCU-TE TESTS

OUTCOME: The employee will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):

- a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

OCCU-TX TREATMENT

OUTCOME: The employee 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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

OCCU-WC WOUND CARE

OUTCOME: The employee will understand proper wound care and infection control measures.

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.

5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

ODM - Ocular Diabetes Mellitus

ODM-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

ODM-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to ocular diabetes mellitus.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with ocular diabetes mellitus as a life-altering illness that requires a change in lifestyle (**refer to [“ODM-LA Lifestyle Adaptations](#)”).**
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with ocular diabetes mellitus, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).**
6. Refer to a mental health agency or provider.

ODM-C COMPLICATIONS

OUTCOME: The patient will understand the ocular complications of diabetes.

STANDARDS:

1. Explain that the ocular complications of diabetes result from high blood glucose and that good control of blood glucose helps prevent loss of vision.
2. Discuss that glaucoma, cataracts, vision loss and/or blindness are complications of ODM.

ODM-CM CASE MANAGEMENT

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

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.”](#)

ODM-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the effect 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 vision loss or total blindness.
2. Discuss that microvascular changes secondary to hyperglycemia can lead to retinal detachment and blindness.
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. Control blood glucose before ordering new glasses.
4. Explain that the damage caused by ocular diabetes is not reversible but effective treatment can delay progression.

ODM-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in ocular diabetes mellitus.

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 improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.

4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

ODM-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

ODM-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of ocular diabetes mellitus.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

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/family will understand the lifestyle adaptations for ocular diabetes mellitus.

STANDARDS:

1. Explain that lifestyle adaptations are the key components to preventing or delaying the progression of ODM.
2. Emphasize that nutrition and physical activity aid in weight loss and are critical components in addressing insulin resistance.
3. Explain that use of tobacco products can exacerbate the disease process and lead to loss of vision.

ODM-LT LASER THERAPY

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 of 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 for the procedure.
4. Discuss pain management as appropriate.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

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 its use in developing a plan to manage pain.
2. Explain that pain management is specific to the disease process and the patient; and may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.
5. Discuss symptoms which should prompt an evaluation such as increasing pain unresponsive to the usual measures.

ODM-PRO PROCEDURE

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 of 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 for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

ODM-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to ocular diabetes mellitus.

STANDARDS:

1. Explain that loss of vision may increase the risk of falls or other injury.
2. Discuss ways the patient can reduce the risk of falls or injury in the home such as:
 - a. clear travel paths in hallways and through rooms that eliminate trip hazards
 - b. paint doors and their trims contrasting colors from the walls and use gentle self-closing devices on doors and cabinets
 - c. mark all steps and handrails with contrasting colors
 - d. lighting sources should be bright and consistent throughout the house. Use flat paints on the wall and window blinds/shades to reduce glare
 - e. recommend appliances with controls on the front
 - f. install grab bars for the tub and shower
3. Discuss the ability to operate motorized vehicles.

ODM-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 that a variety of tests may be performed to assess vision and eye health, such as vision chart, eye exam, visual field, ultrasound, glaucoma test, angiography.
2. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
3. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

ODM-TLH TELE-HEALTH

OUTCOME: The patient/family will have a basic understanding of teleophthalmology.

STANDARDS:

1. Explain that digital images of the eye are acquired and transmitted to the qualified ophthalmologists for interpretation.
2. Explain the purpose of the assessment is for eye complications resulting from diabetes and that there is no preparation required.

ODM-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 participation with treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the need to modify, as appropriate, the treatment plan for underlying diabetes, hypertension, etc. Stress tobacco avoidance.
5. Discuss the importance of maintaining a positive mental attitude.

ODD - Oppositional Defiant Disorder

ODD-C COMPLICATIONS

OUTCOME: The patient/family will understand the possible complications related to Oppositional Defiant Disorder.

STANDARDS:

1. Explain that Oppositional Defiant Disorder may be associated with school suspension, problems at home, problems with work adjustment, risky sexual behavior, early tobacco, alcohol, and drug use.
2. Explain that individuals diagnosed with Oppositional Defiant Disorder are also at risk for developing Learning or Communication Disorders, Conduct Disorder (refer to [“COND - Conduct Disorder”](#)), Attention Deficit Hyperactivity Disorder (refer to [“ADHD - Attention-Deficit/Hyperactivity Disorder”](#)), Posttraumatic Stress Disorder (refer to [“PTSD - Posttraumatic Stress Disorder”](#)), other Anxiety and Mood Disorders, and Substance-Related Disorders (refer to [“AOD - Alcohol and Other Drugs”](#)).

ODD-CM CASE MANAGEMENT

OUTCOME: The patient/family will understand the importance of integrated case management in treating Oppositional Defiant Disorder.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family members, 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”](#).

ODD-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.

2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

ODD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of Oppositional Defiant Disorder.

STANDARDS:

1. Explain that Oppositional Defiant Disorder is a pattern of negativistic, hostile, and defiant behavior, which is significantly less severe than Conduct Disorder, and doesn't include aggression, theft, deceit, or destruction of property. It usually includes at least four of the following symptoms:
 - a. Often loses temper
 - b. Often argues with adults
 - c. Often actively defies or refuses to comply with adults' requests or rules
 - d. Often deliberately annoys people
 - e. Often blames others for one's mistakes or misbehavior
 - f. Is often touchy or easily annoyed by others
 - g. Is often angry and resentful
 - h. Is often spiteful and vindictive
2. Explain the associated features of Oppositional Defiant Disorder, including low self-esteem, mood lability, low frustration tolerance, swearing, and precocious use of alcohol, tobacco, and illicit drugs.
3. Discuss the course of Oppositional Defiant Disorder:
 - a. It usually occurs by the age of 8, is rarely diagnosed after early adolescence, and has a gradual onset.
 - b. The oppositional symptoms often emerge in the home setting, but over time may appear in other settings as well.
 - c. In a significant portion of cases, the disorder may gradually progress into Conduct Disorder.
4. Explain that the disturbance causes clinically significant impairment in social, academic, or occupational functioning, does not occur exclusively during the course of a psychotic or mood disorder, nor Conduct Disorder.
5. Oppositional Defiant Disorder is more prevalent in families in which child care is disrupted by a succession of different caregivers or in families in which harsh, inconsistent, or neglectful child-rearing practices are common.

ODD-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in maintaining health in individuals diagnosed with Oppositional Defiant Disorder.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

ODD-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of regular follow-up in the treatment of Oppositional Defiant Disorder.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up.
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.

ODD-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:

- a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

ODD-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.

ODD-L LITERATURE

OUTCOME: The patient/family will receive literature about Oppositional Defiant Disorder.

STANDARDS:

1. Provide the patient/family with literature on Oppositional Defiant Disorder.
2. Discuss the content of the literature.

ODD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for Oppositional Defiant Disorder.

STANDARDS:

1. Discuss lifestyle adaptations specific to Oppositional Defiant Disorder, such as following rules, being respectful of self and others, and taking responsibility for one's own feelings and actions.
2. Discuss that the family may also require lifestyle adaptations to care for the patient, including creating greater structure in the home, being more involved with the child, taking responsibility for the child making all behavioral health appointments, and consistency in enforcing rules.
3. Discuss ways to optimize quality of life.

4. Refer to community services, resources, or support groups, as available.

ODD-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

ODD-PA PARENTING

OUTCOME: The patient/family will understand the parenting issues related to Oppositional Defiant Disorder.

STANDARDS:

1. Discuss the appropriate methods for applying rewards and consequences to the patient with Oppositional Defiant Disorder.
2. Emphasize the importance of consistency in applying rewards and consequences to change specific behaviors.
3. Discuss the need for appropriate physical and emotional involvement with child, which may include specific activities to improve the relationship.
4. Refer the parent(s) to parenting classes as appropriate.

ODD-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of Oppositional Defiant Disorder.

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. Emphasize that full participation and follow-up is critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain that the therapist and the patient will establish goals and duration of therapy together

ODD-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to Oppositional Defiant Disorder.

STANDARDS:

1. Discuss/review the safety plan and/or administrative treatment plan with the patient and family, including the no-harm contract and emergency procedures.
2. Review the local resources and phone numbers, including the police that may be utilized during a crisis, and may assist in transportation and safety compliance.

ODD-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in Oppositional Defiant Disorder.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect on the condition and precipitate depression or agitation.
2. Explain the role of effective stress management in preventing and/or abating mood changes and/or decompensation.
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.

ODD-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

ODD-TX TREATMENT

OUTCOME: The patient/family will understand the course of treatment and options for Oppositional Defiant Disorder.

STANDARDS:

1. Explain that a combination of psychotherapy and medication interventions usually has better results than therapy or medication alone. The patient has a right to choose either option or both, and that the patient's active participation in the treatment decisions is critical to a good outcome.
2. Explain that therapists have different styles and orientations for treating Oppositional Defiant Disorder, and that no one approach has been shown to be more effective than others, although some styles may suit the patient better.
 - a. Therapy may include anger management groups (in addition to individual psychotherapy) and the exploration and treatment of underlying traumatic events and co-occurring disorders.
 - b. Treatment is optimized when parents attend parenting classes, adjunct family therapy sessions, or their own individual psychotherapy sessions.

3. Explain that medications may be prescribed intermittently or throughout the treatment process. Explain that decisions about timing and duration of medication will be made jointly by the provider(s) and the patient.

TPLNT - Organ Donation/Transplant

TPLNT-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to organ or tissue donated or transplanted.

STANDARDS:

1. Explain the normal anatomy and physiology of the organ or tissue.
 - a. Organ transplantation involves replacing an individual's (the recipient) damaged or failing organ, such as heart, kidney, liver, lung, pancreas, or intestine, with a working organ from another individual (the donor).
 - b. Tissues that are transplanted include bones, tendons, corneas, heart valves, veins, and skin.
2. Discuss the changes to anatomy and physiology as a result of donation or transplantation.
3. Discuss the impact of these changes on the patient's health or well-being.

TPLNT-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to organ or tissue donation or transplantation.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being an organ or tissue donor or recipient, and how it may require a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being an organ or tissue donor or recipient, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to ["AOD - Alcohol and Other Drugs"](#).**
6. Refer to a mental health agency or provider.

TPLNT-C COMPLICATIONS

OUTCOME: The patient/family will understand the common complications associated with organ or tissue donation or implantation.

STANDARDS:

1. Discuss common complications of organ or tissue donation or implantation:
 - a. Transmission of infections from the donor to the recipient.
 - b. Rejection of the transplanted organ or tissue.
 - c. Compromised immune response due to medications necessary to prevent rejection of a transplanted organ.
2. Describe the signs/symptoms of common complications of surgery, as applicable.

TPLNT-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in organ or tissue donation or implantation.

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”](#).**

TPLNT-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

TPLNT-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up as it relates to organ or tissue donation or implantation.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

TPLNT-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding organ or tissue donation or implantation.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding organ or tissue donation or implantation and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

TPLNT-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals

- d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

TPLNT-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to organ or tissue donation or implantation.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.

TPLNT-L LITERATURE

OUTCOME: The patient/family will receive literature about organ or tissue donation or implantation.

STANDARDS:

1. Provide the patient/family with literature on organ or tissue donation or implantation.
2. Discuss the content of the literature.

TPLNT-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for organ or tissue donation or implantation.

STANDARDS:

1. Discuss lifestyle adaptations specific to organ or tissue donation or implantation.

2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

TPLNT-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

TPLNT-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for organ or tissue donation or implantation.

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.

TPLNT-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to organ or tissue donation or implantation.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Review specific nutritional management as it relates to organ or tissue donation or implantation.
6. Refer to registered dietitian for MNT or other local resources as appropriate.

TPLNT-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.

3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

TPLNT-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

TPLNT-PRO PROCEDURE

OUTCOME: The patient/family will understand the proposed procedure, including the indications, complications, and alternatives, as well as, possible results of non-treatment. The patient/family will understand the option to donate or decline to donate organs, tissues, or eyes.

STANDARDS:

1. Discuss organ tissue donation. Refer to trained personnel for further information.
2. Discuss the indications, risks, and benefits of the proposed procedure as well as the alternatives and the risk of non-treatment.
 - a. For a potential donor: Document that the patient or family accepts or declines the opportunity for the patient to become an organ, tissue, or eye donor.

- b. For a potential recipient: Document that the patient or family accepts or declines the opportunity to receive an organ, tissue, or eye donation.
3. Explain the process and what is expected after the procedure.
4. Explain the necessary preparation for the procedure.
5. Discuss pain management as appropriate.

TPLNT-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to organ or tissue donation or implantation.

STANDARDS:

1. Discuss safety risks associated with organ or tissue donation or implantation.
2. Explain the procedures in place for minimizing safety risks associated with organ or tissue donation or implantation.

TPLNT-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

TPLNT-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

TPLNT-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

TPLNT-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.

5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

ORTH - Orthopedics

ORTH-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/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-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.

ORTH-DP DISEASE PROCESS

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

STANDARDS:

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

ORTH-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate (when appropriate) the proper use and care of 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 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/family will understand the importance of follow-up in the treatment of orthopedic conditions.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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 on 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

ORTH-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for treatment or management of the specific type of orthopedic condition/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 as vitamin or mineral deficiencies. Refer to a registered dietitian 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 complications.

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 its 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. Discuss the indications, risks, and 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

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”](#).**
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

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 test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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 reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

OA - Osteoarthritis

OA-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

OA-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to osteoarthritis.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with osteoarthritis as a life-altering illness that requires a change in lifestyle (**refer to [“OA-LA Lifestyle Adaptations](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with osteoarthritis, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#)**.
6. Refer to a mental health agency or provider.

OA-C COMPLICATIONS

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

STANDARDS:

1. Discuss that progressive osteoarthritis can result in loss of range of motion.
2. Discuss the impact of the complications based on the joint(s) involved.

OA-CM CASE MANAGEMENT

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

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”](#).

OA-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

OA-DP DISEASE PROCESS

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

STANDARDS:

1. Review the disease process of osteoarthritis. Osteoarthritis occurs with failure of a movable, synovial-lined joint due to thinning of joint surface, weakening and splitting of cartilage. The most common joints affected are joints of the neck, back, hands, knees, and hips, and joint involvement is often asymmetric.
2. Explain the high prevalence of osteoarthritis as the most common joint disease.
3. Discuss the possible cause of OA as primary (idiopathic) or secondary to another cause (e.g., trauma, congenital/developmental, metabolic, obesity, rheumatoid arthritis).
4. Discuss applicable risk factors for the development or worsening of OA: age (65 years of age and older, and nearly everyone over 75), female gender, genetics,

obesity, occupation-related repetitive injury, physical trauma, congenital/developmental defects, and metabolic/endocrine disease.

5. Explain and discuss the signs and symptoms of OA. Diagnosis of OA is based on symptoms, physical examination, and absence of systemic findings, minimal articular inflammation, and radiography. Symptoms may include:
 - a. Pain upon awakening or pain at long periods of rest (early osteoarthritis: localized, increased with activity, and resolving with rest; late osteoarthritis: pain at rest)
 - b. Stiffness (after periods of inactivity, commonly, morning stiffness, usually lasting less than 30 minutes)
 - c. Bony enlargement
 - d. Crepitus on motion (cracking-like sensation)
 - e. Limited joint motion
 - f. Radiographic evidence (early: no change; moderate: joint space narrowing, late: deformity osteophytes, “lipping”)
6. Refer to the National Arthritis Foundation self help course and book, community resources, or Web site, as appropriate.

OA-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

OA-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

OA-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

OA-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding osteoarthritis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding osteoarthritis and dealing with issues.
2. Provide the help line phone number or Internet address (URL), such as http://www.niams.nih.gov/Health_Info/Osteoarthritis/osteoarthritis_ff.asp

OA-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of osteoarthritis.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

OA-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

OA-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to osteoarthritis.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.

- c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

OA-L LITERATURE

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

STANDARDS:

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

OA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for osteoarthritis.

STANDARDS:

1. Discuss lifestyle adaptations specific to osteoarthritis.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

OA-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

OA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for osteoarthritis.

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.

OA-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to osteoarthritis.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that eating foods rich in omega-3-fatty acids found in fish, walnuts, and flaxseed several times a week may help suppress inflammation.

5. Refer to registered dietitian for MNT or other local resources as appropriate.

OA-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient and may be multifaceted. Refer to [“PM - Pain Management”](#).
3. Explain that medications may be helpful to control pain and the symptoms associated with pain.
4. Explain non-pharmacologic measures that may be helpful with pain control, e.g., use of heat and cold, physical therapy, weight loss.

OA-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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

OA-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. Explain this may include visits with the physical therapist as well as home exercises. **Refer to [“PT - Physical Therapy](#).**
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.

OA-S SAFETY

OUTCOME: The patient/family/caregiver will understand the importance of injury prevention and will 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 remove throw rugs, install safety bars in hallways and near stairs.
3. Stress the importance and proper use of mobility devices (cane, walker, electric scooters, and wheelchair).
4. Explain the importance of recognizing driving limitations. Refer to the community resources, as appropriate.

OA-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in osteoarthritis.
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.

OA-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

OA-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 participation in the treatment plan.

2. Discuss therapies that may be utilized, such as exercise, medications, alternative therapies, joint injections, or surgery, such as joint replacement.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

OS - Osteoporosis

OS-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

OS-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to osteoporosis.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with osteoporosis as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with osteoporosis, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).**
6. Refer to a mental health agency or provider.

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 that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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.”](#)**
3. State that progressive bone loss may result in fractures and/or pain. **Refer to [“OS-C Complications.”](#)**
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 will understand 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 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 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.”](#)**
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/family will understand the importance of follow-up in the treatment of osteoporosis.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding osteoporosis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding osteoporosis and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

OS-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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](#).**
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 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 may be multifaceted. **Refer to [“PM - Pain Management](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.

4. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain. such as nausea and vomiting.
5. Explain non-pharmacologic measures that may be helpful with pain control.

OS-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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.”](#)**

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-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to ostomy.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with ostomy as a life-altering illness that requires a change in lifestyle (**refer to [“OST-LA Lifestyle Adaptations](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with ostomy, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#)**.
6. Refer to a mental health agency or provider.

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](#), [“CRN - Crohn’s Disease](#), [“DIV - Diverticulitis/Diverticulosis](#), and [“UC - Ulcerative Colitis](#)**).
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](#).**
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. Emphasize the importance of follow-up care. Write down questions that can be discussed at the follow-up visit. Discuss the individual's patient's in the management of the 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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding Ostomy.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding Ostomy and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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 colostomy.
 - 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](#). 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

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](#).**
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”](#).**
3. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.

OEX - Otitis Externa

OEX-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to otitis externa, also known as swimmer's ear.

STANDARDS:

1. Explain the normal anatomy and physiology of external auditory canal and ear.
2. Discuss the changes to anatomy and physiology as a result of otitis externa.
3. Discuss the impact of these changes on the patient's health or well-being.

OEX-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of inflammation of the external auditory canal.

STANDARDS:

1. Discuss the effects of acute and chronic otitis extern.
2. Discuss that unless visualization of the tympanic membrane is observed and found to be intact, flushing of the external canal should not be attempted. Small perforations are often missed and a tympanic membrane already weakened by infection can be disrupted.
3. Discuss that individuals with diabetes or disorders of the immune system are more like to get external otitis. It can progress to bony ear canal and the soft tissues leading to malignant otitis externa.
4. Discuss that other conditions may require further evaluation.

OEX-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the otitis externa.

STANDARDS:

1. Discuss that otitis externa is an inflammation of the external auditory canal and is often caused by bacteria, fungus, or non-infectious or dermatologic conditions.
2. Discuss that the most common presenting symptoms of otitis externa are ear pain and drainage. Discomfort can range from itching to severe pain that is made worse by motion of the ear, including chewing. Patients may also complain of ear fullness and loss of hearing.
3. Explain the long-term effects of chronic otitis externa as appropriate.

OEX-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

OEX-L LITERATURE

OUTCOME: The patient/family will receive literature about otitis externa.

STANDARDS:

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

OEX-M MEDICATIONS

OUTCOME: The patient/family will understand the use of medications in otitis externa.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the importance of completing the course of antibiotics (to eradicate the infection and reduce the likelihood of emergence of resistant organisms) as appropriate.
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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
6. 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.

OEX-P PREVENTION

OUTCOME: The patient/family will understand some ways to decrease recurrence of otitis externa.

STANDARDS:

1. Discuss that if symptoms of acute external otitis are beginning, avoid washing hair, or swimming. Drying the external ear can help to prevent infections in person prone to otitis externa.
2. Explain that the ear canal is self cleaning and self-drying (evaporation). Avoid inserting anything into the ear canal to reduce otitis externa.
3. Explain that otitis externa commonly occurs in swimmers/divers. Avoid prolonged swimming, avoid swimming in polluted water, and dry out the ear after swimming.

OEX-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.”](#)**
2. Explain that medications (such as acetaminophen, non-steroidal anti-inflammatory or drops) may be helpful to control the symptoms of pain.
3. Explain non-pharmacologic measures that may be helpful with pain control.

OEX-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.

4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

OEX-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

OEX-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.

3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

OM - Otitis Media

OM-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

OM-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of otitis media (OM).

STANDARDS:

1. Explain that most ear infections don't cause long-term complications but frequent or persistent infections and persistent fluid build-up can result in some serious complications.
2. Discuss the possible complications of chronic OM and/or chronic middle ear fluid:
 - a. mild hearing loss can occur but is usually temporary; more significant hearing loss can occur as a result of persistent infection or persistent fluid in the middle ear
 - b. infants and toddlers may experience delay in speech, social, and developmental skills if hearing is temporarily or permanently impaired
 - c. infection may spread to the mastoid bone behind the ear (mastoiditis); this infection is extremely rare
 - d. tympanic membrane may rupture; this is caused by pressure on the eardrum due to build up of fluid in the middle ear; it usually heals itself in a couple weeks

OM-DP DISEASE PROCESS

OUTCOME: The patient/family will better understand the disease process of otitis media.

STANDARDS:

1. Explain otitis media is an infection of the middle ear which occurs when fluid builds up behind the eardrum. OM can be caused by bacteria or virus.

2. Discuss OM is more common in children than adults because the child's eustachian tubes are smaller and straighter, making it easier for bacteria to enter the middle ear.
3. Discuss common symptoms of OM:
 - a. ear pain; for children who cannot localize pain, watch for other signs like rubbing or tugging on the ear and fussiness or irritability.
 - b. difficulty hearing or lack of response to sounds in infants, young children.
 - c. ringing in the ears
 - d. dizziness
 - e. nausea, vomiting, or loss of appetite
 - f. fever; especially in infants and young children
 - g. fluid draining from the ear
4. Discuss that OM is multifactorial and may be related to illnesses and other factors including:
 - a. allergies
 - b. upper respiratory infection such as a cold or flu
 - c. infected or overgrown adenoids
 - d. exposure to smoke (tobacco, wood smoke used for cooking/heating)
 - e. baby drinking from a bottle while lying on the back
5. Discuss the common myths about otitis media, e.g., things that do not cause OM (i.e., getting water in the ear, failure to cover the ear in the wind, or exposure to cold air, etc.).

OM-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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 (i.e., pain or swelling behind or around the ear, continued fever or ear pain, child acts lethargic, responds poorly, or is inconsolable).

5. Discuss the availability of community resources and support services and refer as appropriate, (i.e., specialty referrals such as ENT specialist, audiologist, speech therapist).

OM-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of otitis media.

STANDARDS:

1. Explain the home management techniques for individuals with OM:
 - a. apply warm compresses to the ear to relieve pain;
 - b. if cigarette smoker, quit; do not smoke near children; avoid exposure to second/third hand smoke; patronize smoke free facilities or businesses; (**refer to ["OM-SHS Second-Hand/Third-Hand Smoke"](#)**)
 - c. give prescribed medications as directed (i.e. antibiotics, ear drops)
 - d. to manage pain or fever, over-the-counter medications may be given as directed (i.e., ibuprofen or acetaminophen); do not give aspirin to children under 18 years of age.
2. Discuss the implementation of hygiene and infection control measures:
 - a. wash hands frequently to prevent the spread of germs which can help prevent exposure to a cold or the flu
 - b. limit or avoid exposure to people who are sick
 - c. do not allow children to share toys they put in their mouth; disinfect toys before allowing children to play with them again
3. Discuss participation in activities for individuals who have an ear infection:
 - a. swimming is okay as long as there is no perforation of the eardrum or drainage from the ear; ask healthcare provider if earplugs are needed
 - b. air travel is safe, although temporary pain is possible during takeoff and landing; chew gum on descent or have child suck on a pacifier to help relieve discomfort during air travel
 - c. return to work, school, or daycare when feeling better and fever is gone

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 otitis media.

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, as appropriate; frequent facilities or businesses that are smoke-free. **Refer to [“OM-SHS Second-Hand/Third-Hand Smoke”](#).**
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”](#).**
4. Explain that breastfeeding has been shown to lower the incidence of ear infections; antibodies in breast milk reduce the risk of ear infections.
5. Discuss the need to limit or avoid exposure to people who are sick.

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 full participation with the medication plan and that this is the patient’s responsibility. Discuss any barriers to full participation.
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 the use of analgesia in pain control. **Refer to [“OM-PM Pain Management”](#).**

OM-P PREVENTION

OUTCOME: The patient/family will understand some ways to reduce the risk of developing otitis media (ear infection).

STANDARDS:

1. Explain the best way to prevent ear infections is to reduce the risk factors associated with them:
 - a. Breastfeed the baby during the first 6 to 12 months of life; breast milk contains antibodies that may offer protection from ear infections.
 - b. Feed child upright if bottle fed to prevent fluid from flowing into the eustachian tubes; do not lay baby down when bottle feeding; encourage weaning from the bottle by one year of age. **Refer to [“CHT-W Weaning”](#).**
 - c. Do not allow the child to drink from a sippy cup while lying down.
 - d. Stop smoking and avoid all exposure to second/third hand smoke. Children exposed to smoke have more episodes of OM. **Refer to [“OM-SHS Second-Hand/Third-Hand Smoke”](#).**
 - e. Avoid contact with known allergy-causing agents.
 - f. Wash hands frequently to prevent the spread of germs which can help prevent exposure to a cold or the flu.
 - g. Limit or avoid exposure to people who are sick.

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”](#) and [“SPE - Surgical Procedures and Endoscopy”](#).**
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”](#).**
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-PRO PROCEDURE

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, 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, (i.e., myringotomy, adneoidectomy).
2. Explain the process and what is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

OM-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. **Refer to [“AF-REF Referral Process”](#).**
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

OM-SHS SECOND-HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Explain that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, and many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia, SIDS, and lung cancer.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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.

OM-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered(i.e., tympanometry, audiometry); explain as appropriate:
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)

- e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

OM-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Explain that in children, if symptoms are not severe, patient is otherwise healthy and older than six months of age, observation and comfort care may be appropriate, and if symptoms resolve in a few days, no antibiotics may be necessary.

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

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

STANDARDS:

1. Explain the normal anatomy and physiology of affected area.
2. Discuss the changes to anatomy and physiology as it relates to pain.
3. Explain the impact of these changes on the patient's health or well-being.

PM-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to pain management.

STANDARDS:

1. Discuss the common difficulty in coping with pain and the necessary change in lifestyle (refer to ["PM-LA Lifestyle Adaptations"](#)).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in pain, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. Refer to ["AOD - Alcohol and Other Drugs"](#).
6. Refer to a mental health agency or provider.

PM-CM CASE MANAGEMENT

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

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”](#).**

PM-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

PM-DP DISEASE PROCESS

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

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 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 understand and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
 - g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

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 chronic pain.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.

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-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes

PM-L LITERATURE

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

STANDARDS:

1. Provide the 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 necessary for pain management.

STANDARDS:

1. Discuss lifestyle adaptations specific to the patient's pain.

2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

PM-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

PM-MNT MEDICAL NUTRITION THERAPY

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

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. Review dietary measures to aid in relief of constipation.
2. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
3. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
4. Discuss the importance of regular meals and adequate fluid intake.
5. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
6. Refer to registered dietitian for MNT or other local resources as appropriate.

PM-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce the risk of developing increased pain related to the disease process or injury.

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 goals and process of psychotherapy in the treatment of pain management.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.

6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

PM-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to pain management.

STANDARDS:

1. Explain the importance of body mechanics to avoid injury.
2. Assist in identifying ways to improve safety and prevent injury in the home.
3. Stress the importance and proper use of mobility devices, for example cane, walker, wheel chair.
4. Discuss safety while operating motor vehicle/heavy equipment while on pain medication.

PM-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

PM-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the risks and benefits of non-invasive and alternative pain relief measures e.g., medications, TENS unit, heat, cold, massage, meditation, imagery, acupuncture, healing touch, traditional healer, and hypnosis.
5. Discuss the possible appropriate procedural or operative pain management techniques e.g., nerve block, intrathecal narcotics, local anesthesia.
6. Discuss the importance of maintaining a positive mental attitude.

PC - Pancreatitis

PC-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

PC-C COMPLICATIONS

OUTCOME: The patient/family will understand common complications of pancreatitis.

STANDARDS:

1. Explain that complications of pancreatitis include sepsis, acute renal failure, hypovolemia, circulatory shock, and pancreatic necrosis. diabetes.
2. Explain that some patients with acute pancreatitis go on to have chronic pancreatitis.
3. Discuss that abdominal pain can become chronic.

PC-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

PC-DP DISEASE PROCESS

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

STANDARDS:

1. Explain that pancreatitis is an inflammation of the pancreas caused by activation of digestion enzymes produced by the pancreas.
2. Discuss 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. Explain that some common causes, e.g., chronic alcohol ingestion, high triglycerides, biliary tract disease, postoperative or post-trauma, metabolic conditions, infections, drug-associated, connective tissue disorders with vasculitis.

PC-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

PC-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding pancreatitis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding pancreatitis and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for pancreatitis.

STANDARDS:

1. Discuss lifestyle adaptations specific to pancreatitis.
2. Discuss that family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

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 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.

PC-MNT MEDICAL NUTRITION THERAPY

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

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.

PC-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition in preventing or minimizing future episodes of pancreatitis.

STANDARDS:

1. Review the relationship between alcohol and pancreatitis and emphasize the importance of total abstinence from alcohol.
2. Explain the necessity of nutrition support via total parenteral nutrition (TPN) as appropriate.
3. Explain that coffee, tea, nicotine, and other gastric stimulants should be avoided.
4. Explain that in many cases a regular diet may be very gradually resumed and eating small frequent meals that are bland is best.
5. Discuss tips for handling nausea and vomiting (e.g., dry meals, taking liquids a few hours before or after meals, use of ice chips, sipping beverages).
6. Assist the patient in developing an appropriate diet plan, and refer to a registered dietitian as appropriate.

PC-P PREVENTION

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

STANDARDS:

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

PC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
5. Explain non-pharmacologic measures that may be helpful with pain control.

PC-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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

PC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):

- a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

PC-TX TREATMENT

OUTCOME: The patient 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 participation with treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.

PANIC - Panic Disorder

PANIC-C COMPLICATIONS

OUTCOME: The patient/family will understand some of the complications associated with Panic Disorder.

STANDARDS:

1. Explain that individuals diagnosed with Panic Disorder also report constant or intermittent anxiety between panic attacks that often disrupt job duties, interpersonal relationships, and recreational activities.
2. Explain that demoralization is a common consequence of Panic Disorder, with many individuals becoming discouraged, ashamed, and unhappy about the difficulties of carrying out their normal routines.
3. Explain that individuals with Panic Disorder may often develop Major Depressive Disorder (**refer to [“DEP - Depressive Disorders](#)**), have co-morbidity with other anxiety disorders, and develop a Substance-Related Disorder as a consequence of self-medicating the anxiety.

PANIC-CM CASE MANAGEMENT

OUTCOME: The patient/family will understand the importance of integrated case management in the treatment of Panic Disorder.

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](#).**

PANIC-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.

2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the treatment plan must be followed as prescribed to be effective.

PANIC-DP DISEASE PROCESS

OUTCOME: The patient/family will understand some of the current information about the symptoms and expected course of Panic Disorder.

STANDARDS:

1. Explain that the essential features of Panic Disorder include:
 - a. The presence of recurrent (at least two), *unexpected* panic attacks (that is only one among three types of attacks that are common in anxiety disorders, including situationally-bound and situationally predisposed panic attacks).
 - b. At least one month of persistent concern about having another panic attack, worry about the implications or consequences of a panic attack, or a significant behavioral change related to the attacks, such as quitting a job due to the panic.
2. Explain that a panic attack is a discrete period of intense fear or discomfort which includes at least four of the following symptoms that develop abruptly and reach a peak within 10 minutes:
 - a. Palpitations, pounding heart, or accelerated heart rate
 - b. Sweating
 - c. Trembling or shaking
 - d. Sensations of shortness of breath or smothering
 - e. Feelings of choking
 - f. Chest pain or discomfort
 - g. Nausea or abdominal distress
 - h. Feeling dizzy, unsteady, light-headed or faint
 - i. Derealization or depersonalization
 - j. Fear of losing control or going crazy
 - k. Fear of dying
 - l. Paresthesias (numbness or tingling sensations)
 - m. Chills or hot flashes
3. Individuals who experience panic attacks develop a tendency to magnify normal body sensations and to interpret them catastrophically, such as sensing an increase in heart rate during exercise and believing that it is a heart attack, which then triggers a sympathetic nervous system response.

4. Explain that the age of onset for Panic Disorder varies considerably, but is most typically between late adolescents and the mid-30s. Explain that the usual course is chronic, but waxing and waning, while others may have episodic outbreaks with years of remission in between, or continuous, recurrent severe symptomatology.
5. Explain that individuals with Panic Disorder display characteristic concerns or beliefs that run counter to medical testing and reassurance, such as the presence of an undiagnosed, life-threatening illness (e.g., cardiac disease, seizure disorder, or hypertensive distress).

PANIC-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 role that exercise will have in raising body awareness, and thereby improve one's ability to manage the panic symptoms more effectively.
3. Discuss the other benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
4. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
5. Encourage the patient to increase the intensity and duration of the activity when becoming more fit.
6. Refer to community resources as appropriate.

PANIC-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

PANIC-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.

PANIC-L LITERATURE

OUTCOME: The patient/family will receive literature about Panic Disorder.

STANDARDS:

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

PANIC-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

PANIC-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of Panic Disorder.

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 classes, talking circles, or other modalities.
3. Emphasize that full participation and follow-up is critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility,
6. Explain that the therapist and the patient will establish goals and duration of therapy together.

PANIC-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in treating Panic Disorder.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in Panic Disorder, which is actually a key component to reduction of panic symptoms.
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.

PANIC-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

PANIC-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options for Panic Disorder.

STANDARDS:

1. Explain that a combination of psychotherapy and medication interventions usually has better results than therapy or medication alone. The patient has a right to choose either option or both, and that the patient's active participation in the treatment decisions is critical to a good outcome.
2. Explain that therapists have different styles and orientations for treating Panic Disorder.
 - a. Cognitive Behavioral Therapy and techniques have been shown to be effective in treating panic by helping patients to break the association between the physiological arousal and the catastrophic thoughts, and introducing new coping statements and stress management techniques.
 - b. Some therapists have had success in using other techniques and orientations to address other unresolved problems that may have exacerbated or given rise to anxiety and panic attacks.
 - c. Eclectic techniques have also been shown to be effective in encouraging remission.
3. Explain that medications may be prescribed intermittently or throughout the treatment process, although it is often discouraged because treatments that entail building a tolerance to the symptoms may delay remission or worsen the condition when the medication is stopped. Explain that decisions about timing and duration of medication will be made jointly by the provider(s) and the patient.

PRK - Parkinson Disease

PRK-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to Parkinson disease (PD).

STANDARDS:

1. Explain the normal anatomy and physiology of neuro-muscular pathways. The brain produces dopamine, which allows smooth, coordinated function of the body's muscles.
2. Explain that PD is a brain disorder that occurs when certain nerve cells in the substantia nigra die or become impaired. When enough dopamine-producing cells are damaged, the symptoms of PD appear.
3. Discuss the impact of these changes on the patient's health or well-being.

PRK-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to Parkinson disease (PD).

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with PD as a life-altering illness that requires a change in lifestyle (**refer to [“PRK-LA Lifestyle Adaptations](#)”).**
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with PD, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Explain that patients may learn to overcome the initial emotional reactions and to live healthy, productive lives. Explain that help is available.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).”**
6. Refer to a mental health agency or mental health provider.

PRK-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of Parkinson disease (PD).

STANDARDS:

1. Discuss physical complications of PD such as: tremors, stiffness, rigidity, slow or purposeful movements, difficulty speaking, shaky handwriting, tendency to fall, and depression.
2. Describe that as PD progresses, patients may have difficulty in adjusting psychologically to the challenges that PD may present. These difficulties may also impact others close to the patient and can include:
 - a. Persistently high levels of anxiety
 - b. Intrusive thoughts
 - c. Body self-absorption
 - d. Hypersensitivity
 - e. Social withdrawal
 - f. Inability to tolerate frustration
 - g. Anger
 - h. Depression

PRK-CM CASE MANAGEMENT

OUTCOME: The patient/family will understand the importance of integrated case management in Parkinson disease (PD).

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”](#).**

PRK-DP DISEASE PROCESS

OUTCOME: The patient/family will understand Parkinson disease (PD) and its impact on the individual/family/caregiver.

STANDARDS:

1. Discuss that the PD has no cure. It is a progressive movement disorder.
2. Emphasize the risk factors including: age greater than 65 and family history of PD.

3. Discuss that signs and symptoms begin mildly but worsen over time. These include:
 - a. tremors
 - b. stiffness and rigidity of muscle (usually starts on one side of the body)
 - c. short steps
 - d. slow or purposeful movements
 - e. difficulty speaking (flat monotone voice, stuttering)
 - f. shaky or spidery handwriting
 - g. instability of gait
 - h. depression
 - i. difficulty thinking or problem solving
4. Discuss that late stages of PD involve significant movement disorders that disrupt activities of daily living.

PRK-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
 - g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

PRK-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in Parkinson disease (PD).

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

PRK-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of Parkinson disease (PD).

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

PRK-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding Parkinson Disease.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding Parkinson Disease and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

PRK-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state resulting from healthy choices.

2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

PRK-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to Parkinson disease (PD).

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.
6. Explain that as PD progresses, patients will require help in daily hygiene routines.

PRK-L LITERATURE

OUTCOME: The parent(s) and family will receive literature about Parkinson disease (PD).

STANDARDS:

1. Provide the parent(s) and family with literature on Parkinson disease.
2. Discuss the content of the literature about PD.

PRK-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for Parkinson disease (PD).

STANDARDS:

1. Discuss lifestyle adaptations specific to PD.
2. Discuss that family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

PRK-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

PRK-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for Parkinson 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.

PRK-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to Parkinson disease (PD).

STANDARDS:

1. Discuss the importance of adequate fluid intake.
2. Explain that using semisolid foods rather than fluids if sucking/swallowing reflexes are reduced may improve a patient's ability to eat. Using a liquid thickener is helpful.
3. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal. A vitamin and mineral supplement is recommended. Small, frequent feedings are best.
4. Explain that as PD progresses, the use of nutrition support such as enteral feeding or total parenteral feeding may be necessary.
5. Refer to registered dietitian for MNT.

PRK-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

PRK-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to Parkinson disease (PD).

STANDARDS:

1. Explain the risks of operating machinery and driving.
2. Discuss use of safety features to help prevent falls due to instability.
 - a. Wear non-skid slippers or flat shoes when out of bed.
 - b. Avoid throw rugs, electrical cords, objects on the floor, unlevel or wet floors, and stairs.
 - c. Be aware of pets or small children playing on the floor.
 - d. Obtain assistance when getting up from bed or seated position.
 - e. Obtain and use assistive mobility devices, as recommended.

PRK-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in Parkinson disease (PD).

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in PD.
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.

PRK-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

PRK-TX TREATMENT

OUTCOME: The patient/family will understand the treatment plan for Parkinson disease (PD).

STANDARD

1. Explain that the treatment goal is not to extinguish all signs of PD (that leads to over-treatment), but to maintain functionality.
2. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation with treatment plan.
3. Discuss therapies that may be utilized.
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.

PNL - Perinatal Loss

PNL-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to perinatal loss.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of perinatal loss as a life-altering condition that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in perinatal loss, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the importance of seeking help in accepting and coping with the loss.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#).**
6. Refer to a mental health agency or provider, as necessary.

PNL-C COMPLICATIONS

OUTCOME: The patient will understand some complications of perinatal loss.

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 perinatal loss may develop complications if it remains unexpressed, if it is exaggerated, if grief from previous losses resurfaces, or if it is masked by significant physical/behavioral symptoms, such as angry outbursts or somatizations.
3. Explain that relationship difficulties are common after perinatal loss. Encourage open discussion and family counseling or support groups as appropriate.
4. Discuss that unresolved loss or survivor guilt may further result in the development of Major Depressive Disorder (**refer to [“DEP - Depressive Disorders”](#)**), Posttraumatic Stress Disorder (**refer to [“PTSD - Posttraumatic Stress Disorder”](#)**), Substance-Related Disorders (**Refer to [“AOD - Alcohol and Other Drugs”](#)**), and Somatoform Disorders (**refer to [“SOMA - Somatoform Disorders”](#)**).

PNL-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 their perception of loss and the grieving process.

STANDARDS:

1. Discuss the influence that their social, cultural, and spiritual traditions and variables have on the patient/family's perception of grief.
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
3. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

PNL-DP DISEASE PROCESS

OUTCOME: The patient/significant others(s) will understand the type of perinatal loss, 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.
6. Explain that "normal" grieving/bereavement may vary considerably among different cultural groups, and discuss the patient/family's perception of grief, including the social, spiritual, and cultural influences on their perceptions.

PNL-FU FOLLOW UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

PNL-GP GRIEVING PROCESS

OUTCOME: The patient/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 it is normal to grieve over the loss of the baby, that everyone may grieve differently, and that different reactions are normal. Offer grief information and different options to assist their grieving process.
3. Explain that physiologic changes, like milk coming in or hormonal fluctuations, may exacerbate grief.
4. Explain that anniversary reactions, increased grief during trigger events (e.g., pregnancy of a friend or family member, holidays) are normal.
5. Discuss the various options available to help with the grieving process.
6. As appropriate, encourage viewing of the infant/fetus, picture taking, and naming of the infant/fetus.

PNL-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and

substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.

3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

PNL-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, based on the assessment of their social, cultural, and spiritual needs.
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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. Encourage continued use of prenatal vitamins as appropriate.

PNL-MNT MEDICAL NUTRITION THERAPY

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

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 dietitian or other resources as available.

PNL-PM PAIN MANAGEMENT

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

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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
5. Explain non-pharmacologic measures that may be helpful with pain control.

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 the loss, as well as, help improve the 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

- 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.

PNL-TX TREATMENT

OUTCOME: The patient/family will understand the medical and psychological 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.
3. Explain that individual psychotherapy is the treatment of choice to facilitate the grieving process because the symptoms are an understandable reaction to a loss, which often involves:
 - a. Developing or enhancing coping skills
 - b. Understanding how the stressor effected their lives
 - c. Developing alternate social or recreational activities
4. Explain that medication interventions are not usually prescribed for loss, although anti-depressants or anti-anxiety medications may be prescribed in conjunction with therapy for short periods to improve sleep, co-occurring disorders (e.g., Major Depression), or overall functioning.
5. Discuss how to integrate the social, cultural, or spiritual traditions of the patient and family into the treatment process, based on the assessment of their needs and perceptions about loss.

PERIO - Periodontal Disease

(Correlates to American Dental Association (ADA) code 1330)

PERIO-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.
2. Explain the importance of healthy gum tissue.
3. Explain what healthy gum tissue looks like. Explain the characteristics of unhealthy gum tissue versus healthy gum tissue.

PERIO-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
 - f. Elevated blood sugar
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”](#).**

PERIO-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. Discuss the role of certain medications; poor oral hygiene and local factors (i.e., braces and malocclusion) in the development of periodontal disease.
3. Explain that early seeding of the mouth with pathologic bacteria may predispose to the development of periodontal disease.

PERIO-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care as well as home care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

PERIO-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.

- c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes

PERIO-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.

PERIO-L LITERATURE

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

STANDARDS:

1. Provide the patient/family with literature on periodontal disease, treatment and/or the oral care necessary for prevention/maintenance of disease.
2. Discuss the content of the literature.

PERIO-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

PERIO-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 that with bone loss there is an increased risk of root caries. 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.

PERIO-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.

PERIO-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".**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

PERIO-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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

PERIO-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)

- e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

PERIO-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 tobacco cessation. If the patient is not ready to stop tobacco, emphasize the importance of cutting back on the amount of tobacco in an effort to quit. **Refer to ["TO - Tobacco Use"](#).**

PERIO-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 participation in the treatment plan.
2. Discuss therapies that may be utilized, e.g., daily plaque removal, use of oral rinses.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.

PERIO-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.

2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

PVD - Peripheral Vascular Disease

PVD-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family 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 many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is able to provide guidance at the time that decisions need to be made.
3. Explain that the Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences of care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.

PVD-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to peripheral vascular disease (PVD).

STANDARDS:

1. Explain the normal anatomy and physiology of vascular system.
2. Discuss the anatomy and physiology changes to arteries, veins, or lymph vessels as a result of peripheral vascular disease.
3. Discuss the impact of these changes on the patient's health or well-being.

PVD-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to peripheral vascular disease.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with peripheral vascular disease as a life-altering illness that requires a change in lifestyle (refer to [“PVD-LA Lifestyle Adaptations](#)).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with peripheral vascular disease, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. Refer to [“AOD - Alcohol and Other Drugs](#).
6. Refer to a mental health agency or provider.

PVD-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of peripheral vascular disease (PVD).

STANDARDS:

1. Discuss common and important complications of PVD, e.g., numbness, tingling in the lower extremities, pain, infection, injury, gangrene, erectile dysfunction, or disability and/or amputation.
2. Describe the signs/symptoms of common complications of PVD.
3. Emphasize the importance of early medical intervention for any injury, increased pain, decreased sensation, or signs/symptoms of infection (pain, redness, warmth).

PVD-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in peripheral vascular disease (PVD).

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”](#).

PVD-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

PVD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of peripheral vascular disease (PVD).

STANDARDS:

1. Explain that PVD is caused by the occlusion of an artery by a clot or by plaque buildup in the interior walls of the vessels in the extremities (hands and feet).
2. Explain that PVD is a chronic, progressive, and treatable disease.
3. Explain that causes of PVD include heavy smoking, arterial embolism, obesity, diabetes mellitus, hypertension, and atherosclerosis. Emphasize that patients with PVD are at greatly increased risk for other vascular diseases (CAD, CVA).
4. Discuss the symptoms of PVD (pain in extremities during exercise, coolness of hands and/or feet, ulcers of the extremities, skin pallor).

PVD-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in peripheral vascular disease (PVD).

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity in improving PVD.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.

4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

PVD-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of peripheral vascular disease (PVD).

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

PVD-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding peripheral vascular disease (PVD).

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding PVD and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

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. Discuss lifestyle adaptations specific to PVD.
2. Emphasize the importance of the patient's adaptation to a healthier and lower risk lifestyle in the treatment of peripheral vascular disease.
3. Explain that lifestyle adaptations such as tobacco cessation, control of blood pressure, diabetes, and cholesterol via diet, physical activity, and weight loss may reduce the progression of peripheral vascular disease.

4. Discuss that the family may also require lifestyle adaptations to care for the patient.
5. Discuss ways to optimize quality of life.
6. Refer to community services, resources, or support groups, as available.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

PVD-MNT MEDICAL NUTRITION THERAPY

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

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 nutrition, as it relates to peripheral vascular disease (PVD).

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain the need for a low fat and high fiber diet. Discuss the benefits of adding omega 3 fatty acids to diet.
5. Refer to registered dietician for MNT.

PVD-P PREVENTION

OUTCOME: The patient/family will understand how to prevent peripheral vascular disease (PVD).

STANDARDS:

1. Explain the benefits of a low fat diet, regular physical activity, achieving a healthy weight, and blood pressure control in reducing the risk for PVD.
2. Explain that people with uncontrolled diabetes and/or blood pressure are more likely to develop PVD. Stress the importance of controlling these disease processes. **Refer to [“DM - Diabetes Mellitus](#) and [“HTN - Hypertension](#).**
3. Stress the importance of tobacco cessation. **Refer to [“TO-OT Quit](#).**

PVD-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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.

4. Explain non-pharmacologic measures that may be helpful with pain control.

PVD-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

PVD-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. **Refer to [“AF-REF Referral Process”](#).**
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

PVD-SCR SCREENING

OUTCOME: The patient/family will understand the proposed screening including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed screening, e.g., Ankle-Brachial Index, Ultrasound for Abdominal Aortic Aneurysm in male smokers over age 65. Refer to [“PVD-TE Tests](#).
2. Explain the process and what to expect after the screening.
3. Emphasize the importance of follow-up care.

PVD-SHS SECOND-HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Explain that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, carcinogens.
3. Explain the increased risk of illness when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia, SIDS, and lung cancer.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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.

PVD-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered, such as Doppler ultrasound, angiography. Explain as appropriate:
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)

- e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
- a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

PVD-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

PVD-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.

6. Discuss any special recommendations or instructions particular to the patient's wound.

PERSD - Personality Disorder

PERSD-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications related to personality disorders.

STANDARDS:

1. Explain that individuals with personality disorders are at risk for committing suicide or repeatedly threatening suicide as a manipulative ploy, which must always be taken seriously.
2. Explain that individuals with personality disorders are at risk of developing psychotic symptoms or disorders (**refer to [“PSYD - Psychotic Disorders](#)**), including hallucinations, body-image distortions, ideas of reference, and hypnagogic phenomena.
3. Explain that individuals diagnosed with personality disorders also often have other associated disorders, including other personality disorders or features, Major Depressive Disorder (**refer to [“DEP - Depressive Disorders](#)**), and Substance-Related Disorders (**refer to [“AOD - Alcohol and Other Drugs](#)**).

PERSD-CM CASE MANAGEMENT

OUTCOME: The patient/family will understand the importance of integrated case management in treating personality disorders.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family members, 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](#).**

PERSD-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.

2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

PERSD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of the personality disorder under consideration.

STANDARDS:

1. Discuss the general diagnostic criteria for a personality disorder:
 - a. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture that can be traced back to adolescence, and is manifested by:
 - i. Cognition, i.e., ways of perceiving and interpreting self, other people, and events
 - ii. Affectivity, i.e., range, intensity, lability, and appropriateness of emotional responses
 - iii. Interpersonal functioning
 - iv. Impulse control
 - b. The enduring pattern has the following attributes:
 - i. Is inflexible and pervasive across a broad range of personal and social situations
 - ii. Is stable and of long duration
 - iii. Leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning
2. Explain the essential features of the personality disorder under consideration:
 - a. **Borderline Personality Disorder** is a pattern of instability in interpersonal relationship, self-image, affects, and marked impulsivity, that is characterized by feelings of emptiness, fear and frantic avoidance of abandonment, inability to maintain healthy relationships, self-sabotage, recurrent suicidal ideation and gestures, marked reactivity of mood (e.g., intense anger), and manipulative behavior.
 - b. **Antisocial Personality Disorder** is a pattern of disregard for, and violation of, the rights of others, as characterized by deceitfulness, superficial charm, irresponsibility, irritability, lack of remorse, and reckless disregard for the law and the safety of self and others.
 - c. **Narcissistic Personality Disorder** is a pattern of grandiosity, need for admiration, and lack of empathy, as characterized by a sense of entitlement,

- exploitation, devaluation, and arrogance with a concomitant underlying feeling of insecurity, worthlessness, and need for external validation.
- d. **Histrionic Personality Disorder** is a pattern of excessive emotionality and attention seeking, characterized by a need to be the center of attention, emotional shallowness, self-dramatization, and theatricality.
 - e. **Dependent Personality Disorder** is a pattern of submissiveness and clinging behavior related to excessive need to be taken care of.
 - f. **Avoidant Personality Disorder** is a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.
 - g. **Obsessive-Compulsive Personality Disorder** is a pattern of preoccupation with orderliness, perfectionism, and control, but which does not have the true obsessions and compulsions as seen in the Axis I Obsessive-Compulsive Disorder (refer to [“OCD - Obsessive-Compulsive Disorder”](#)).
 - h. **Paranoid, Schizoid, and Schizotypal Personality Disorders** represent a cluster of disorders that are characterized by individuals who appear odd or eccentric, distrustful, limited in range of emotion, and uncomfortable in relationships, which must be distinguished from Axis I psychotic Disorders (refer to [“PSYD - Psychotic Disorders”](#)).
 - i. **Personality Disorder Not Otherwise Specified (NOS)** is used in two situations:
 - The individual’s personality pattern meets the general criteria for a personality disorder, and the traits of several different personality disorders are present without full criteria for any specific disorder.
 - The individual is deemed to have a personality disorder under general criteria, but is not included in the classifications above.
3. Explain that the interpersonal difficulties in individuals with personality disorders include outright avoidance, overt argumentativeness, sabotage (e.g., unfaithfulness), secretiveness, recurrent complaining, lack of trust, lack of empathy, hostile aloofness, and manipulations (e.g., seeking to control their partner through emotional manipulation or seductiveness on the one hand and displaying a marked dependency on the other).
 4. Explain that personality disorders are considered Axis II diagnoses and usually have other concomitant Axis I diagnoses.
 5. Explain that Paranoid, Schizoid, and/or Schizotypal Personality Disorders may often precede, follow, or co-exist with psychotic disorders (refer to [“PSYD - Psychotic Disorders”](#)).

PERSD-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in maintaining health in individuals diagnosed with personality disorders.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

PERSD-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

PERSD-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.

- d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

PERSD-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.

PERSD-L LITERATURE

OUTCOME: The patient/family will receive literature about the specific personality disorder.

STANDARDS:

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

PERSD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for personality disorders.

STANDARDS:

1. Discuss lifestyle adaptations specific to the personality disorder under consideration, such as following rules, being respectful of self and others, avoiding risky behavior, abiding by commitments, plans, and contracts, including safety contracts and treatment plans, and taking responsibility for one's own feelings and actions.
2. Discuss that the family may also require lifestyle adaptations to care for the patient, such as avoiding enabling behaviors.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

PERSD-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. Medication may be prescribed to address aggressive behaviors, mood lability, social anxiety, or other symptoms of co-occurring disorders.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

PERSD-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of personality disorders.

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. Emphasize that full participation and follow-up is critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain that the therapist and the patient will establish goals and duration of therapy together

PERSD-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to personality disorders, and the risk of suicide, aggressive behavior, or other risky behavior.

STANDARDS:

1. Discuss/review the safety plan with the patient and family, including the no-harm contract and emergency procedures.
2. Review the local resources and phone numbers, including the police that may be utilized during a crisis, and may assist in transportation and safety compliance.

PERSD-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect on the condition and precipitate depression, irritability, or agitation.
2. Explain the role of effective stress management in preventing and/or abating mood changes and/or decompensation.
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.

PERSD-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

PERSD-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options for personality disorders.

STANDARDS:

1. Explain that a combination of psychotherapy and medication interventions usually has better results than therapy or medication alone. The patient has a right to choose either option or both, and that the patient's active participation in the treatment decisions is critical to a good outcome.
2. Explain that therapists have different styles and orientations for treating the different personality disorders, and some styles may suit the patient better.
 - a. Administrative treatment plans are often useful to improve communication among providers, to prevent the patient's manipulations or splitting staff members, and to prevent suicidal or aggressive behaviors.
 - b. The treatment of choice for Borderline Personality Disorder usually includes Dialectical Behavior Therapy (DBT), in group and individual formats. DBT incorporates methods for initially reducing therapy-interfering behaviors and suicidal/homicidal gestures, followed by affect identification and tolerance techniques, and trauma work.
 - c. Individuals with Antisocial Personality Disorder usually do not learn from past experiences and therefore usually do not profit from therapy.
 - d. Treating the personality disorders usually takes a long time and requires much effort and insight by the patient.
3. Explain that medications may be prescribed intermittently or throughout the treatment process.
 - a. Medication may be prescribed to address aggressive behaviors, mood lability, anxiety, or other symptoms of personality and co-occurring disorders.

- b. Explain that decisions about timing and duration of medication will be made jointly by the provider(s) and the patient.
4. Explain the importance for patients to learn to talk about any traumatic experiences in the safe context of the therapeutic environment. Support groups may be useful as well.

PDD - Pervasive Developmental Disorders

PDD-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to Pervasive Developmental Disorders.

STANDARDS:

1. Discuss the common difficulty for families coping with the impact of a family member being diagnosed with a Pervasive Developmental Disorder as a life-long illness that requires a change in lifestyle for the caretakers (**refer to [“PDD-LA Lifestyle Adaptations”](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common for families who learn about the diagnosis.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#)**.

PDD-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications associated with Pervasive Developmental Disorders.

STANDARDS:

1. Explain that individuals with Pervasive Developmental Disorders often develop a range of behavioral symptoms, including hyperactivity, short attention span, impulsivity, aggressiveness, self-injurious behavior, and temper tantrums.
2. Explain that seizures and EEG abnormalities may develop in adolescents with Pervasive Developmental Disorders.

PDD-CM CASE MANAGEMENT

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

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, school/teachers, 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”](#).**

PDD-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

PDD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of Pervasive Developmental Disorders.

STANDARDS:

1. Explain that Pervasive Developmental Disorders are characterized by severe impairment and deviance in several areas of development:
 - a. **Reciprocal social interaction** including non-verbal behaviors such as eye contact, facial expressions, and body postures;
 - b. **Communication skills** including marked delay in spoken language, stereotyped language, and inability to sustain a conversation.
 - c. **Presence of stereotyped behaviors, interests, and activities** including abnormal preoccupation with restrictive patterns of interest and inflexible adherence to non-functional routines.
2. Discuss the specific Pervasive Developmental Disorder:
 - a. **Autistic Disorder** is diagnosed before the age of three years, and includes impairment in all areas of development.
 - b. **Rett’s Disorder** is characterized by normal prenatal and perinatal development and normal psychomotor development through the first five months of life, followed by a deceleration of head growth, loss of previously acquired hand skills, poorly coordinated gait, and regression in developmental skills.

- c. **Childhood Disintegrative Disorder** is characterized by apparently normal development for at least the first two years of life followed by significant loss of previously acquired developmental skills.
 - d. **Asperger's Disorder** is characterized by some impairment in development except there is no delay in language, cognitive development, self-help skills, and adaptive behavior.
 - e. **Pervasive Developmental Disorder Not Otherwise Specified** includes other developmental conditions that do not meet the criteria for any specific Disorder.
3. Explain that in most cases, the Pervasive Developmental Disorders include abnormalities of mood, behavior, eating patterns, and the development of cognitive skills.
 4. Explain that the specific causes of PDD are not known, although they are presumed to be related to Central Nervous System dysfunction. There is no link between autism and vaccines containing thimerosal.
 5. Explain that Pervasive Developmental Disorders are usually life-long and include a co-morbid diagnosis of Mental Retardation (**refer to ["MR - Mental Retardation"](#)**), although the course and development of each condition is distinctive and variable, depending on the condition and its severity.

PDD-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in maintaining health and wellness.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

PDD-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.

2. Discuss the procedure and process for obtaining follow-up appointments.
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.

PDD-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding pervasive developmental disorders.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding pervasive developmental disorders.
2. Provide the help line phone number or Internet address (URL).

PDD-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

PDD-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to Pervasive Developmental Disorders.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

PDD-IR INFORMATION AND REFERRAL

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

STANDARDS:

1. Explain that the family may seek professional assistance when they have concerns about the individual's development, when they notice other disorders that need treatment, or when the child's motor or language skills are not developing normally.
2. Provide the patient/family with alternative or additional sources for care and services.
3. Provide the patient/family with assistance in securing alternative or additional resources as needed.

PDD-L LITERATURE

OUTCOME: The patient/family will receive literature about Pervasive Developmental Disorders.

STANDARDS:

1. Provide the patient/family with literature on Pervasive Developmental Disorders.
2. Discuss the content of the literature.

PDD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for Pervasive Developmental Disorders.

STANDARDS:

1. Discuss that the family may also require lifestyle adaptations to care for the patient, including the skills needed for special needs.
2. Discuss ways to optimize quality of life.
3. Refer to community services, resources, or support groups, as available.

PDD-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

PDD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for Pervasive Developmental Disorders.

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.

PDD-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to Pervasive Developmental Disorders.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

PDD-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to Pervasive Developmental Disorders and the risk of harm to self or others.

STANDARDS:

1. Discuss the potential consequences of the individual's limitations in self-care, problem solving, conflict resolution, and impulse control.
2. Discuss the importance of providing a safe environment, as appropriate. **Refer to ["CHT-S Safety"](#).**
3. Discuss/review the safety plan with the patient and family, including emergency procedures should the individual decompensate in terms of emotional stability and behavioral control.
4. Review the local resources and phone numbers, including the police, who may be utilized during a crisis, and may assist in transportation and safety compliance.

PDD-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in coping with emotional instability and behavioral problems associated with Pervasive Developmental Disorders.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in coping with emotional instability and behavioral problems associated with Pervasive Developmental Disorders.
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.

PDD-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.

3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

PDD-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 participation in the treatment plan.
 - a. Explain that some children require highly structured, specialized classrooms with attention to specific academic needs, while other are able to function in a regular classroom with less specialized attention.
 - b. Explain that treatment may also include:
 - i. Speech Therapy
 - ii. Occupational Therapy
 - iii. Social Skills Training
 - iv. Behavioral Therapy
2. Explain the importance of treating any associated conditions or co-occurring conditions, including depression and aggressive behaviors.
3. Explain that medication is beneficial for some symptoms of PDD and associated conditions.
4. Discuss the importance of support groups and programs for the family or caregivers of the individual.
5. Discuss the prognosis for the individual, which may vary according to the cause and severity of the Pervasive Developmental Disorder, the opportunities afforded the individual, and treatment outcomes. Some individuals may lead productive lives and function on their own, while others need structured living environments.

PHOB - Phobias

PHOB-C COMPLICATIONS

OUTCOME: The patient/family will understand some of the complications associated with phobias.

STANDARDS:

1. Explain that there is frequent co-occurrence of phobias with other anxiety disorders, especially Panic Disorder. Sometimes full panic attacks are experienced in response to the phobic stimulus.
2. Explain that phobias often result in restricted lifestyles or interference with certain occupations, such as avoiding a job promotion because it requires extensive travel, and one experiences anticipatory anxiety about flying.

PHOB-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the treatment plan must be followed as prescribed to be effective.
3. Review any possible cultural meanings for the specific phobias, such as a fear of snakes arising from a traditional belief in it as a negative omen.

PHOB-DP DISEASE PROCESS

OUTCOME: The patient/family will understand some of the current information about the symptoms and expected course of phobias.

STANDARDS:

1. Discuss the essential feature(s) of the phobic disorder under consideration:
 - a. Explain that **Social Phobia** is a marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others and which is experienced as humiliating or embarrassing.

- b. Explain that **Agoraphobia** is anxiety about being in places or situations from which escape may be difficult or embarrassing or in which help may not be available in the event of having a panic attack. Agoraphobia is usually diagnosed with Panic Disorder (**refer to [“PANIC - Panic Disorder](#)**), and includes characteristic clusters of situations that include being outside the home, being in a crowd, standing in a line, traveling on a bus or train, or being on a bridge.
 - c. Explain that **Specific Phobia** is a marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation. Specific phobias may include:
 - i. Animal Type: spiders, snakes, dogs, cats, etc.
 - ii. Natural Environment Type: heights, storms, water
 - iii. Blood-Injection-Injury Type: includes medical procedures
 - iv. Situational Type: bridges, elevators, flying, enclosed places
 - v. Other Type: fear or avoidance of situations that may lead to choking, vomiting or contracting an illness, falling down
2. Discuss the associated features experienced by the patient, including:
 - a. Exposure to the phobic stimulus almost invariably provokes an anxiety response, which may take the form of a situationally predisposed panic attack.
 - b. Recognizing that the fear is excessive or irrational (except children).
 - c. Avoiding the phobic situation or enduring it with intense anxiety or distress.
 3. Discuss the degree to which anxiety, avoidance, or distress in the feared situation interferes significantly with the patient’s normal routine, occupational/academic functioning, or social activities or relationships. The patient may also have a marked level of distress about having the phobia.
 4. Explain that fears are very common in childhood, and that the phobia must last at least six months and must impair social, academic, or recreational functioning to warrant the diagnosis for individuals under 18 years of age.

PHOB-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 role that exercise will have in raising body awareness, and thereby improve one’s ability to manage the phobic symptoms more effectively.

3. Discuss the other benefits of any physical activity, such as well being, stress reduction, sleep, bowel regulation, and self image.
4. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
5. Encourage the patient to increase the intensity and duration of the activity when becoming more fit.
6. Refer to community resources as appropriate.

PHOB-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

PHOB-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding phobias.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding phobias and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

PHOB-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.

PHOB-L LITERATURE

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

STANDARDS:

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

PHOB-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

PHOB-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of phobias.

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 classes, talking circles, or other modalities.
3. Emphasize that full participation and follow-up is critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.

5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain that the therapist and the patient will establish goals and duration of therapy together.

PHOB-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in phobias, which is actually a key component to reduction of anxiety.
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.

PHOB-TX TREATMENT

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

STANDARDS:

1. Explain that the patient has a right to choose combination of psychotherapy, medication interventions, or both, but that:
 - a. psychotherapeutic techniques alone have been shown to be effective in reducing or eliminating symptoms of phobias,

- b. medication management is only necessary if the patient is unable to function effectively,
 - c. the patient's active participation in the treatment decisions is critical to a good outcome.
2. Explain that therapists have different styles and orientations for treating phobias.
 - a. Cognitive Behavioral Therapy and techniques have been shown to be effective in treating phobias including systematic desensitization and visualization techniques.
 - b. Other eclectic techniques have also been effective in eliminating phobic symptoms/phobias, including hypnosis and Eye Movement Desensitization and Reprocessing (EMDR).
 - c. Some therapists have had success in using other techniques and orientations to address other unresolved problems that may have exacerbated or given rise to the underlying anxiety.
3. Explain that medications may be prescribed intermittently or throughout the treatment process, Explain that decisions about timing and duration of medication will be made jointly by the provider(s) and the patient.

PT - Physical Therapy

PT-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

PT-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the patient's physical condition.

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-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 which may include orthotic, protective, and support devices pertaining to the physical findings, diagnosis, and prognosis. 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. Discuss medical clearance issues for physical activity.
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. As appropriate, demonstrate and assist in practicing the exercise(s) in the program
5. Discuss and emphasize the importance of following the customized exercise plan developed with the Physical Therapist to achieve optimal benefit.
6. Review the exercise programs available in the community.

PT-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

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 the physical condition as it relates to the 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-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand functional training in work (job, school, play community) and leisure integration or reintegration.

STANDARDS:

1. Discuss and provide recommendations related to barrier accommodations or modifications.
2. Discuss functional training programs e.g. back schools, job coaching, simulated environments and tasks, task adaptation; task training, work conditioning, work hardening, and IADL training (work training with tools).
3. Injury prevention or reduction e.g. injury prevention education during work (job, school, play) and community.
4. Injury prevention education with use of devices and equipment.
5. Discuss safety awareness training during work (job, school, play) and community.
6. Explain leisure integration or reintegration and play activities and training.

PT-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for physical therapy.

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 role of nutrition and physical therapy.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.

2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Refer to registered dietician for MNT as needed.

PT-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

PT-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. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

PNM - Pneumonia

PNM-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

PNM-C COMPLICATIONS

OUTCOME: The patient/family will understand and identify symptoms associated with pneumonia.

STANDARDS:

1. Discuss the possible complications, e.g., pleural effusion, sustained hypotension, shock, and other infections such as bacterium, and atelectasis due to mucus plugs.
2. Explain that complications may be prevented with prompt treatment with appropriate antibiotic therapy.
3. Explain that if cough, fever, or shortness of breath worsen or do not improve, to seek medical attention.
4. Explain the common symptoms such as fever, cough, chest pain, shortness of breath.

PNM-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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 following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

PNM-EX EXERCISE

OUTCOME: The patient will be able to demonstrate appropriate deep breathing and coughing exercises.

STANDARDS:

1. Instruct patient in deep breathing and coughing 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. Emphasize the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointment.
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-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for pneumonia.

STANDARDS:

1. Discuss lifestyle adaptations specific to pneumonia.
2. Discuss that family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

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.
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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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/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 to promote healing.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Discuss that small frequent meals may be better tolerated.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietician for MNT.

PNM-P PREVENTION

OUTCOME: The patient/family will understand the actions that may be taken to prevent pneumonia.

STANDARDS:

1. Instruct patient to avoid second-hand smoke and contact with respiratory infections.
2. Discuss the importance of tobacco cessation. **Refer to ["TO - Tobacco Use](#).**
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](#).**

PNM-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
5. Explain non-pharmacologic measures that may be helpful with pain control.

PNM-SHS SECOND-HAND/THIRD-HAND SMOKE

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

STANDARDS:

1. Explain that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, and many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness when exposed to cigarette smoke either directly or via second-hand/third-hand smoke.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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-OT Quit.”](#)**

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, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

PNM-TO TOBACCO (SMOKING)

OUTCOME: The patient/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](#).**

PNM-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Explain that antibiotics are necessary to treat the pneumonia. **Refer to [“PNM-M Medications](#).**
5. 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 follow-up in the treatment of poisoning.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

POI-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a poison help line.

STANDARDS:

1. Explain that the poison help line will provide immediate information regarding poisoning and immediate management.
2. Provide the help line phone number and explain that it is available 24/7. 1-800-222-1222.
3. Explain how the poison help line works and what can be expected from calling and/or participating in the services.

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.

POI-L LITERATURE

OUTCOME: The patient/family will receive literature about poison prevention.

STANDARDS:

1. Provide the patient/family with literature on 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 in their original containers and stored safely and out of reach of children.
2. Explain to parents the necessity of discussing poison control with their children. Emphasize to parents to impress upon their children that medication is not candy.
3. Emphasize that child-locks, child-resistant medication containers and other child safety devices are not truly child proof.
4. Explain that poisonous chemicals should not be stored in food or drink containers. Poisonous chemical should be kept in original, properly labeled containers.

POI-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan

- d. recommendations based on the test results

POI-TX TREATMENT

OUTCOME: The patient/family will understand the components of the treatment plan and 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 [“SI - Suicidal Ideation and Gestures.”](#)

PP - Postpartum

PP-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of the female reproductive system, breasts, and the body as a whole, i.e., constitution as well as weight, edema, anemia, and energy.
2. Discuss the changes to anatomy and physiology as a result of the delivery of an infant, i.e., involution, lochia, after birth cramps, breast engorgement (breastfeeding or not), weight loss, hair loss, and fatigue.
3. Discuss the impact of these changes on the patient's health or well-being.

PP-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components that may take place during and after pregnancy.

STANDARDS:

1. Discuss the common difficulty in coping with the complications of the postpartum period as a life-altering condition that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in the postpartum period. Explain that depression screening is available to assess for depression.
3. Discuss the importance of traditional medical, spiritual, mental/emotional, and cultural components during the postpartum period.
4. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to ["AOD - Alcohol and Other Drugs"](#).**
5. Refer to a mental health agency or provider.

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 are 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 side effect of epidural post anesthesia as appropriate.
5. 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.
6. As appropriate, refer to [“BF - Breastfeeding”](#) and/or refer to [“PDEP - Postpartum Depression”](#).

PP-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

PP-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Discuss Kegel exercises. Refer to [“PP-KE Kegel Exercises”](#).

6. Refer to community resources as appropriate.

PP-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a postpartum, breast feeding, or crisis intervention help line as available.

STANDARDS:

1. Explain that a postpartum, breast feeding or crisis intervention help line will provide immediate information and assistance.
2. Provide the help/crisis intervention line phone number and review the hours of operation.
3. Explain how the help/crisis intervention line works and what can be expected from calling and/or participating in the services.

PP-INF INFANT CARE

OUTCOME: The patient/family will understand the basic principles of infant care.

STANDARDS:

1. Discuss infant care, including diapering, bathing, cord care, burping, skin care, feeding, and benefits/risks for circumcision vs. non-circumcision, as applicable.
2. Explain the importance of protecting not exposing the infant to from second-hand and third-hand smoke. **Refer to ["TO - Tobacco Use"](#).**
3. Explain the proper use and installation of infant car seats. **Refer to ["CHN-CAR Car Seats and Automobile Safety"](#).**

4. Explain that laying the infant on the side or back provides a safe sleep environment. Explain that all infants sneeze. Discuss that nasal secretions are common. Discuss the procedure for using a nasal suction bulb and obligate nose breathers. Discuss other common newborn sounds and behaviors: newborn sigh, startle reflex, twitching during sleep.
5. Explain that infants frequently have rashes that may be normal. Emphasize that it is recommended to check with the healthcare provider.
6. 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-ISEC INFANT SECURITY

OUTCOME: The patient/family will understand the necessary infant security measures.

STANDARDS:

1. Explain the infant security measures that have been implemented to decrease the chances of infant abduction from this facility.
2. Explain the roles and responsibilities parents and visitors have for maintaining infant security.

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-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the postpartum changes.

STANDARDS:

1. Discuss the common postpartum emotional changes, interpersonal relationships, and family dynamics.
 - a. Encourage the patient to share her feelings with her partner, friend, family, healthcare provider.
 - b. Identify stressors that can occur with a newborn in the household. Encourage the patient to “take time for herself and ask for help.”
 - i. Explain that infant sleep patterns differ from adult sleep patterns. Encourage the mother to sleep when the infant sleeps.
 - ii. Emphasize the important of parent-child bonding. Discuss Family Medical Leave Act forms, as applicable.
2. Explain the sexual activity.
3. Discuss options for birth control/contraception. Refer to [“HPDP - Health Promotion, Disease Prevention”](#). Refer to [“FP - Family Planning”](#).

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 full participation with the medication plan and that this is the patient’s responsibility. Discuss any barriers to full participation.
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.

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 nutrition, as it relates to postpartum.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that more calories are required when breast feeding and taking prenatal vitamins is recommended.
5. Refer to a Registered Dietitian for MNT or other local resources as appropriate.

PP-ORAL ORAL HEALTH

OBJECTIVE: The parent/family will understand how maternal health affects dental conditions in the mother and infant.

STANDARDS:

1. Explain that tooth decay (dental carries) is partially caused by strep mutants in the mouth.
2. Explain that this bacterium is transmitted from the mother to the infant. Emphasize the importance of never putting bottle nipples, pacifiers, or utensils in any mouth except the infant's mouth.

PP-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

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. 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 medications may be helpful to control pain from after birth cramping, breast engorgement, or nausea and vomiting.
3. Explain that increasing pain should prompt a visit or call to the patient's provider.
4. 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 reasons to care appropriately for the wound, to decrease infection rate and improve healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

PDEP - Postpartum Depression

PDEP-C COMPLICATIONS

OUTCOME: The patient/family will understand some of the complications associated with postpartum depression.

STANDARDS:

1. Explain that postpartum depression, if left untreated, can:
 - a. interfere with mother-child bonding
 - b. create family problems
 - c. adversely affect self image, hygiene, self worth, etc.
 - d. develop into postpartum psychosis and chronic depressive disorders
2. Explain that children of mothers who have untreated postpartum depression are more likely to have behavioral problems, such as sleeping and eating difficulties, temper tantrums, and hyperactivity, as well as delays in language development.
3. Explain that even when treated, postpartum depression increases a woman's risk of future episodes of major depression.
4. Explain that depression may have adverse effect on the baby, such as withdrawal of breastfeeding and abuse or neglect.

PDEP-CM CASE MANAGEMENT

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

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"](#).

PDEP-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

PDEP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand postpartum depression and its symptoms.

STANDARDS:

1. Explain that postpartum depression is caused by hormonal and other changes in brain chemistry, and is not the mother's fault or the result of a weak or unstable personality. Explain that postpartum depression is common and treatable.
2. Review some of the 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.
3. Describe the symptoms and levels of severity of postpartum depression.
 - a. **Baby Blues:** May last only a few days or weeks, and includes symptoms of tearfulness, irritability, mood swings, nervousness, feelings of vulnerability, difficulty concentrating, trouble sleeping, loss of appetite, lack of confidence, and feeling overwhelmed.
 - b. **PP Depression:** Is more intense and lasts longer than baby blues, and may interfere with ability to care for the baby and handle daily tasks, including symptoms of sadness or despondency, loss of interest in normal activities, inappropriate guilt, anxiety, fatigue, impaired concentration/memory, over concern for baby, hopelessness, panic attacks (**refer to "PANIC - Panic Disorder"**).
 - c. **PP Psychosis:** Is the rarest and most severe form of PP depression, which includes extreme confusion, incoherence, rapid speech or mania, refusal to eat,

paranoia, irrational statements, agitation, hallucinations, bizarre or strange thoughts, or inability to stop an activity.

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. Postpartum depression is reversible with early intervention and appropriate treatment.
5. Explain that patients with coexisting substance abuse may need more rapid referral. Refer to [“AOD - Alcohol and Other Drugs”](#), as appropriate.

PDEP-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity has a positive impact on physical and mental well being.

STANDARDS:

1. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
2. Discuss the demands of a new born or infant and ways to incorporate physical activity in daily routines. Discuss any obstacles to physical activity. Assist the patient in developing a personal exercise plan.
3. Discuss medical clearance issues for physical activity.
4. Refer to community resources as appropriate.

PDEP-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care, especially the immediate follow-up procedure for obtaining urgent and rapid referrals if the patient has:
 - a. suicidal thoughts/plans
 - b. thoughts/plans about harming the infant
 - c. thoughts/plans about harming others
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

PDEP-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient will understand the lifestyle changes necessary to promote healthy living.

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 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.

PDEP-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.

PDEP-L LITERATURE

OUTCOME: The patient/family will receive literature about postpartum depression.

STANDARDS:

1. Provide the 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 recognize or decrease the risk for postpartum depression and to 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 outdoors 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 the provider of all medications, drugs, herbals, and supplements being taken 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.
2. Explain that many medications for postpartum depression do not exert an immediate effect and must be used regularly to be effective.
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.

6. Discuss that some medication may be excreted in breastmilk. Refer the patient to a physician or pharmacist who is knowledgeable in the use of medications during breastfeeding.

PDEP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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 the role of nutrition and postpartum depression.

STANDARDS:

1. Stress the importance of eating on a regular schedule and eating a variety of foods.
2. 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.
3. Assist in developing an appropriate diet plan. Refer to dietitian or other local resources as available.
4. Discuss that overeating can be a symptom of depression and not a healthy behavior.

PDEP-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce the effects of depression or prevent recurrence of depressive episodes.

STANDARDS:

1. Explore any history of depression, especially postpartum depression, and explain the importance of continuous screening for it.
2. Discuss the signs and symptoms of postpartum depression, and the importance of early detection and screening after the baby is born.
3. Explain that a history of postpartum depression may warrant prescription of anti-depressants following delivery.

PDEP-PSY PSYCHOTHERAPY

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

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

PDEP-S SAFETY

OUTCOME: The patient/family will understand the safety plan as it relates to severe depression, and potential harm to self or baby.

STANDARDS:

1. Discuss/review the safety plan with the patient and family, including the no-harm contract and emergency procedures should the condition worsen, if thought to harm self or baby arises, or if the patient feel urges to engage in risky/dangerous behavior.
2. Discuss the importance for screening for domestic violence. **Refer to [“DVV - Domestic Violence - Victim”](#).**
3. Explain that local police may also be available to assist in transportation and safety compliance.

PDEP-SM STRESS MANAGEMENT

OUTCOME: The patient/family 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 and can interfere with treatment. Explain that effective stress management may help reduce the severity of the symptoms of depression.
2. Explain that seeking professional help to improve the health and well-being of the patient is often necessary.
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 severity of the depression or the risk of suicidal/homicidal 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. 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
5. Provide referrals as appropriate.

PDEP-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options for postpartum depression.

STANDARDS:

1. Explain the treatment plan will be made by the patient, family, and treatment team after reviewing available options. Explain that treatment for depression may vary according to the patient's life circumstances, severity of the condition, and available resources.
 - a. Baby blues often resolves on its own with enough rest and family support.
 - b. Postpartum depression may require long-term intervention comprised of one or a combination of interventions, including psychotherapy, medication, hormone therapy, or support groups.
 - c. Postpartum psychosis is more of a treatment challenge because some medications are not recommended for breast-feeding mothers. Explain that mothers with postpartum psychosis have a team of healthcare providers to help treat the symptoms.
2. Explain the lifestyle changes that are an important part of treatment (**refer to [“PDEP-LA Lifestyle Adaptations”](#)**).
3. Encourage 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.
4. Explain that treatment may begin at any point, even prior to pregnancy depending on the circumstance.

PTSD - Posttraumatic Stress Disorder

PTSD-C COMPLICATIONS

OUTCOME: The patient/family/caregiver will understand the complications of posttraumatic stress disorder.

STANDARDS:

1. Explain that complications of PTSD may include phobic avoidance of situations, interference with interpersonal relationships, marital/ family conflict, divorce, or loss of job.
2. Explain that individuals diagnosed with PTSD are at an increased risk of other anxiety disorders, depressive disorders (refer to [“DEP - Depressive Disorders”](#)), somatization disorders (refer to [“SOMA - Somatoform Disorders”](#)), eating disorders (refer to [“EAT - Eating Disorders”](#)), and substance-related disorder (refer to [“AOD - Alcohol and Other Drugs”](#)).
3. Discuss that complications of PTSD may be reduced or avoided by appropriate and timely treatment.

PTSD-CM CASE MANAGEMENT

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

STANDARDS:

1. Discuss 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”](#).

PTSD-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.

2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

PTSD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of posttraumatic stress disorder.

STANDARDS:

1. Explain that PTSD develops from the direct personal experience of a trauma (e.g., actual or threatened death or serious injury, or witnessing an event that involves the death or serious injury of another person), that is associated with intense fear, horror, or helplessness.
2. Explain that the disorder can develop in individuals without any predisposing conditions, particularly if the stressor is especially extreme. Explain that the severity, duration, and proximity of an individual's exposure to the traumatic event are the most important factors affecting the likelihood of developing the disorder.
3. Discuss that the symptoms must be present for three months and the intensity may be variable over the course of the illness. Frequently, the disturbance initially meets the criteria for Acute Stress Disorder.
4. Explain that patients with PTSD persistently experience symptoms of:
 - a. re-experiencing the traumatic event
 - i. nightmares
 - ii. flashbacks or reliving the incident
 - iii. intrusive thoughts
 - iv. intense distress when exposed to reminders of the event
 - b. avoiding stimuli associated with the trauma or detaching from it (emotional numbing)
 - c. having increased arousal, such as:
 - i. sleep disturbance
 - ii. irritability/anger
 - iii. hypervigilance
 - iv. exaggerated startle responses
 - v. difficulty concentrating

PTSD-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in coping with PTSD.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the role that exercise will have in raising body awareness, and thereby improve one's ability to manage their PTSD symptoms more effectively.
3. Discuss the other benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
4. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
5. Encourage the patient to increase the intensity and duration of the activity when becoming more fit.
6. Refer to community resources as appropriate.

PTSD-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

PRSD-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding PTSD.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding PTSD and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

PTSD-L LITERATURE

OUTCOME: The patient/family will receive literature about Posttraumatic Stress Disorder.

STANDARDS:

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

PTSD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for coping with PTSD.

STANDARDS:

1. Discuss lifestyle adaptations specific to PTSD.
2. Discuss that the family may also require lifestyle adaptations.
3. Discuss ways to optimize quality of life.
3. Refer to community services, resources, or support groups, as available.

PTSD-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

PTSD-P PREVENTION

OUTCOME: The patient/family will understand major risk factors for development of chronic PTSD.

STANDARDS:

1. Explain that immediate treatment of acute PTSD or acute stress reaction is critical to preventing further symptoms of chronic PTSD; e.g., debriefing about the incident or de-escalating the symptoms.
2. Discuss that not all traumatic events can be prevented, but high-risk behaviors and exposure to potential trauma can be reduced.

PTSD-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of PTSD.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

PTSD-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in PTSD.
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.

PTSD-TX TREATMENT

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

STANDARDS:

1. Explain that a combination of psychotherapy and medication interventions usually has better results than therapy or medication alone. The patient has a right to choose with either option or both, and that the patient's active participation in the treatment decisions is critical to a good outcome,
2. Explain that therapists have different styles and orientations for treating PTSD, and that no one approach has been shown to be more effective than others, although some styles may suit the patient better. Effective therapies include:
 - a. Individual Psychotherapy
 - i. Eye Movement Desensitization and Reprocessing (EMDR)
 - ii. Cognitive Behavioral Therapy (CBT)
 - Prolonged Exposure (PE)
 - Cognitive Processing Therapy (CPT)
 - iii. Brief Psychodynamic Therapy
 - b. Group Therapy
 - c. Family Therapy
3. Explain that anti-depressant and anti-anxiety medications are effective in reducing symptoms. Explain that decisions about timing and duration of medication will be made jointly by the provider(s) and the patient.
4. Explain the importance for patients to learn to talk about the traumas in the safe context of the therapeutic environment. Support groups with patients who have experienced similar traumas may be useful to this end as well.

PDM - Prediabetes

PDM-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain normal sugar metabolism and pancreatic function.
2. Discuss the changes to anatomy and physiology as a result of prediabetes. Explain that insulin resistance and beta cell damage result in blood sugar levels that are higher than normal but not enough for a diagnosis of diabetes. Explain that prediabetes is often referred to impaired glucose tolerance or Impaired Fasting Glucose (IGT/IFG).
3. Discuss the impact of these changes on the patient's health or well-being.

PDM-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to prediabetes.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with prediabetes as a life-altering illness that requires a change in lifestyle. **Refer to [“PDM-LA Lifestyle Adaptations](#).**
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with prediabetes, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).**
6. Refer to a mental health agency or provider.

PDM-C COMPLICATIONS

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

STANDARDS:

1. Explain that prediabetes will usually progress to Type 2 Diabetes unless preventive measures are taken.
2. Emphasize that optimal control of blood sugar can reverse or prevent progression of prediabetes (PDM) or complications.
3. State that PDM is a disease that needs to be monitored for progression and complications. Routine examinations are essential.
4. Discuss complications that can occur if PDM develops into Diabetes, e.g., heart disease, stroke, eye problems, kidney damage. Refer to [“MSX - Metabolic Syndrome, “CVA - Cerebrovascular Disease, “CAD - Coronary Artery Disease, “DM - Diabetes Mellitus, and “PVD - Peripheral Vascular Disease.](#)

PDM-CM CASE MANAGEMENT

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

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.](#)

PDM-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
4. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

PDM-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the disease process of Prediabetes (PDM).

STANDARDS:

1. Discuss the role of insulin resistance and beta cell dysfunction in PDM and Type 2 diabetes.
2. Describe risk factors for development and progression of PDM, e.g., including: ethnicity, age, family history, obesity, sedentary lifestyle, previous history of gestational diabetes, history of hypertension and dyslipidemia. **Refer to [“MSX - Metabolic Syndrome](#).**
3. Explain that prediabetes will usually progress to Type 2 Diabetes unless preventive measures are taken.
4. Emphasize that PDM is a condition that can be corrected, but requires permanent lifestyle changes and monitoring and medical follow up. **Refer to [“PDM-LA Lifestyle Adaptations](#).**

PDM-EX EXERCISE

OUTCOME: The patient/family will understand physical activity in relation to prediabetes.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as decrease in insulin resistance, weight loss, improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

PDM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in prediabetes (PDM).

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.

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.

PDM-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

PDM-L LITERATURE

OUTCOME: The patient/family will receive literature about prediabetes (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 for prediabetes (PDM).

STANDARDS:

1. Explain that lifestyle adaptations are the key components to preventing or delaying the progression of PDM.
2. Emphasize that nutrition and physical activity aid in weight loss and are critical components in addressing insulin resistance.
3. Explain that use of tobacco products can exacerbate the disease process and lead to complications.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
6. 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 with prediabetes (PDM).

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of reading food labels, appropriate serving sizes, carbohydrate load per meal (carbohydrate counting).
3. Identify techniques or strategies for eating out, social events, traditional eating practices, and family support in managing blood sugar.
4. Explain that emotional eating from boredom, anger, frustration, loneliness, and depression can interfere with blood sugar control, as appropriate. Alternative choices should be recommended.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

PDM-P PREVENTION

OUTCOME: The patient/family will understand major risk factors for development of prediabetes (PDM).

STANDARDS:

1. Discuss the risk factors for PDM, e.g., obesity, sedentary lifestyle. **Refer to [“MSX - Metabolic Syndrome](#).**
2. Explain that following an appropriate meal plan and increasing activity levels will reduce the risk of progression of PDM.
3. Emphasize the importance and recommendations of regular blood sugar monitoring.

PDM-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care with prediabetes.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. achieve and maintain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

PDM-SCR SCREENING

OUTCOME: The patient/family will understand the proposed screening including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed screening.
2. Explain the process and what to expect after the screening.
3. Emphasize the importance of follow-up care.
4. Explain the recommended frequency of various screenings.

PDM-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress can:
 - a. contribute to insulin resistance
 - b. interfere with the treatment of prediabetes
2. Explain that effective stress management may reduce the adverse consequences of prediabetes, as well as help improve the health and well-being of the patient.
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 and lead to diabetes.
4. Discuss various stress management strategies such as maintaining 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 referrals as appropriate.

PDM-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

PDM-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

PDM-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

PN - Prenatal

PN-1T FIRST TRIMESTER (0 TO 12 WEEKS)

OUTCOME: The patient/family will understand the progression of pregnancy during the first trimester.

STANDARDS:

1. Explain the female reproductive organs and fetal growth and development.
 - a. Identify and explain the functions of the ovaries, fallopian tubes, uterus, cervix, placenta, and vagina as they relate to pregnancy. **Refer to [“PN-AP Anatomy And Physiology”](#).**
 - b. Discuss fetal growth and development during pregnancy. During the first trimester emphasize organ development. **Refer to [“PN-GD Growth and Development”](#).**
2. Discuss the course of prenatal care, visit schedule, anticipated tests, etc. **Refer to [“PN-FU Follow-up”](#).**
3. Discuss signs/symptoms that should prompt immediate medical assistance. Identify risks and warning signs for miscarriage (e.g., spotting, bleeding, discharge, cramping, unexplained abdominal pain, unexplained back ache, edema, dysuria, or headache).
4. Discuss the following pregnancy information and all other applicable subtopics listed in prenatal. This information is to be covered over a continuum of prenatal visits.
 - a. Discuss the patient’s responsibility to herself and her growing child. Emphasize the importance of regular prenatal care and rest, prescribed vitamins, and good nutrition. **Refer to [“PN-LA Lifestyle Adaptations”](#).**
 - b. Discuss the importance of good personal hygiene and oral health as it relates to health and positive self-image. **Refer to [“HPDP-HY Hygiene”](#) and [“PN-DC Dental Care”](#).**
 - c. Discuss relief measures for the discomforts of pregnancy. **Refer to [“PN-LA Lifestyle Adaptations”](#).**
 - d. Emphasize the advantages of exclusive breastfeeding for both mother and baby. **Refer to [“BF - Breastfeeding”](#).**
 - e. Discuss appropriate physical activity in pregnancy. Include medical clearance issues and appropriate footwear.
 - f. Discuss important nutrition information in pregnancy such as:
 - i. adequate folate intake before pregnancy and throughout the first trimester
 - ii. daily intake of prescribed prenatal vitamins and minerals

- iii. not eating soft cheeses, raw meats, raw eggs, and raw fish
- iv. supplemental food programs and encourage enrollment (**refer to [“PN-N Nutrition”](#)**)
- g. Explain that a healthy weight is important to prevent birth defects. Refer to Institute Of Medicine guidelines for recommendations for *Total and Rate of Weight Gain During Pregnancy, by Pre-pregnancy BMI*. **Refer to [“PN-N Nutrition”](#)**.
- h. Discuss that consumption of any amount of alcohol during pregnancy can cause Fetal Alcohol Spectrum Disorder (FASD), mental retardation, or other preventable complications. Discuss available treatment or intervention options, as appropriate. **Refer to [“FASD - Fetal Alcohol Syndrome”](#)**.
- i. Discuss the dangers of tobacco use and second-hand exposure in pregnancy. Emphasize the link to low birth weight. **Refer to [“PN-TO Tobacco”](#) and [“PN-SHS Second-Hand/Third-Hand Smoke”](#)**.
- j. Emphasize the importance of complete abstinence from all drugs of abuse. Point out that the use of drugs during pregnancy can result in birth defects, premature birth, low birth weight, and addiction in the new born. Evaluate the patient’s use of substances and refer for treatment as appropriate. **Refer to [“AOD - Alcohol and Other Drugs”](#)**.
- k. Discuss father’s/significant other’s role in pregnancy, including support for the mother, education, and inclusion in the birth plan as appropriate. **Refer to [“PN-LA Lifestyle Adaptations”](#)**.
- l. Discuss sex during pregnancy. Encourage the patient to ask questions. **Refer to [“PN-LA Lifestyle Adaptations”](#)**.
- m. Discuss sexual, emotional, and/or physical abuse. Emphasize that any type of abuse should not be tolerated and should be reported. Discuss the availability of shelters and other support options in the area. Offer a list of resources and make referrals as appropriate. **Refer to [“PN-DV Domestic Violence”](#)**.
- n. Discuss the importance of providing medical emergency contact information
- o. Discuss seatbelt use. Seatbelts should be worn low on the hips and the shoulder belt should lie above the pregnant abdomen. **Refer to [“PN-S Safety”](#)**.
- p. Discuss the dangers of fetal overheating in relation to hot baths, jacuzzis, sweat lodges, heating pads, etc. **Refer to [“PN-S Safety”](#)**.
- q. Discuss the dangers of exposure to infectious diseases, e.g., measles, toxoplasmosis, Sexually Transmitted Infections (STIs) (gonorrhea, chlamydia, syphilis, trichomonas parvovirus (5th Disease), influenza, HIV, group B strep, hepatitis. Explain that HIV testing is a routine part of prenatal care. **Refer to [“PN-STI Sexually Transmitted Infections”](#)**.

- r. Discuss the dangers of eating raw meat, working in the garden without gloves, changing cat litter. Discuss the importance of washing hands after working with dirt or cat litter. Have someone help with these tasks.
- s. Teach the patient to inform all healthcare providers of the pregnancy prior to obtaining treatment, e.g., x-rays, medications. **Refer to [“PN-S Safety”](#).**
- t. Emphasize the importance for enrollment in prepared childbirth and parenting classes or group prenatal care. **Refer to [“PN-SOC Social Health”](#).**
- u. Discuss adoption and abortion, as appropriate. Refer to Community Resources, Behavioral Health, and/or Social Services as appropriate. **Refer to [“PN-SOC Social Health”](#).**

PN-2T SECOND TRIMESTER (13 TO 27 WEEKS)

OUTCOME: The patient/family will understand the progression of pregnancy during the second trimester and ensure (continue/repeat) primary education on the first trimester.

STANDARDS:

1. Discuss all information listed in the first trimester and/or ensure primary education on the first trimester has been completed. Although not listed here for the purposes of this manual, all information in PN-1T should be reviewed as this is a continuum of education. **Refer to [“PN-1T First Trimester \(0 to 12 Weeks\)”](#).**
2. Identify risks and warning signs for preterm labor (e.g., spotting, bleeding, discharge, cramping, unexplained abdominal pain, unexplained back ache, edema, dysuria, or headache). **Refer to [“PN-PTI Pre-term Labor”](#).**
3. Discuss fetal movement and need for evaluation of decreased fetal movement.
4. Explain the importance of procedures or screening tests as appropriate. **Refer to [“PN-TE Tests”](#).**
5. Discuss all other applicable subtopics listed in prenatal that pertain to the second trimester.
 - a. Discuss fetal growth and development in the second trimester.
 - b. Discuss the changes in the mother’s body during the second trimester. Discuss exercise, rest, and relief measures for second trimester discomforts of pregnancy.
 - c. Discuss breastfeeding vs. bottle-feeding. Emphasize the advantages of breastfeeding for both mother and baby. **Refer to [“BF - Breastfeeding”](#).**

PN-3T THIRD TRIMESTER (28 TO 40 WEEKS)

OUTCOME: The patient/family will understand the progression of pregnancy in the third trimester, and ensure primary education on the first and second trimester has been completed.

STANDARDS:

1. Discuss all information listed in the first and second trimester and/or ensure primary education on the first and second trimester has been completed. Although not listed here for the purposes of this manual, all information in PN-1T and PN-2T should also be reviewed as this is a continuum of education. **Refer to [“PN-1T First Trimester \(0 to 12 Weeks\)”](#), [“PN-2T Second Trimester \(13 to 27 Weeks\)”](#).**
2. Discuss third semester information, including:
 - a. Changes in the mother’s body.
 - b. Exercise, rest, and relief measures for third trimester discomforts of pregnancy.
 - c. Discuss the anatomy and physiology of lactation and care of the breasts and nipples. **Refer to [“BF - Breastfeeding”](#).**
 - d. Discuss sex during the late stages of pregnancy and early postpartum period.
 - e. Discuss family planning method to be used postpartum. Review methods of contraception including tubal ligation, and timing related to postpartum period and breast feeding. Explain the time frame of paper work needed prior to tubal ligation. Emphasize the importance of partner participation in family planning. **Refer to [“FP-MT Methods”](#) or [“FP-ST Sterilization”](#) as appropriate.**
 - f. Explain that a bacterium called *Group B strep* may be dangerous to the baby and explain the institution’s screening procedure.
3. Discuss labor:
 - a. Assist the patient in developing a labor plan.
 - b. Discuss the hospital admission routines, e.g., fetal monitoring, IVs, hydration, paired care, rooming in, post partum bonding, induction. **Refer to [“PN-ADM Admission to Hospital”](#).**
 - c. Discuss the signs of impending labor. Emphasize the importance of knowing “when you are in labor.”
 - d. Discuss the three stages of labor.
 - e. Review breathing exercises and other exercises for labor. If feasible, refer the patient for childbirth education classes.
 - f. Discuss those events that require immediate attention, e g., ruptured or leaking membranes, decreased fetal movement, bleeding, and fever. Emphasize the importance of knowing when to seek medical attention.
 - g. Discuss the possibility of a C-section.
 - h. **Refer to [“CB-PRO Procedures, Obstetrical”](#).**
4. Discuss all applicable topics/subtopics listed in prenatal that pertain to first, second and third trimesters. Examples include: Prenatal 1st Trimester ([“PN-1T First Trimester \(0 to 12 Weeks\)”](#)), Prenatal 2nd Trimester ([“PN-2T Second](#)

[Trimester \(13 to 27 Weeks\)](#)"), Childbirth (["CB - Childbirth"](#)), Child Health Newborn (["CHN - Child Health - Newborn \(0-60 Days\)"](#)), Post Partum (["PP - Postpartum"](#)). Highlights from these protocols vital to 3rd trimester education include:

- a. Postpartum - Refer and document in PP-Postpartum
 - i. Discuss the anatomy and physiology of lactation - refer to ["BF - Breast-feeding"](#).
 - ii. Care of the breasts and nipples.
 - iii. Maternal engorgement.
 - iv. Discuss Anatomy and Physiology - refer to ["PP - Postpartum"](#)
 - v. Involution
 - vi. Wound Care
 - vii. Pain management
- b. Behavioral Health
 - i. Postpartum Depression - refer to ["PDEP - Postpartum Depression"](#)
 - ii. Cultural and Spiritual
 - iii. Exercise
 - iv. Complications
 - v. Postpartum Follow up
 - vi. Family Planning confirmation / follow-up - refer to ["FP-IC Implant Contraception"](#)
- c. Infant Care - Refer to ["CHN - Child Health - Newborn \(0-60 Days\)"](#)
 - i. Breastfeeding Refer to ["BF - Breastfeeding"](#)
 - ii. Pediatrician Visits
 - iii. Newborn Care - Refer to ["CHN - Child Health - Newborn \(0-60 Days\)"](#)
 - iv. Infant Bonding / Infant communication
 - v. Car Seat - Refer to ["CHN-CAR Car Seats and Automobile Safety"](#)
 - vi. SIDS

PN-ADM ADMISSIION TO HOSPITAL

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. Who will be the support.
 - d. Where to go for admission. This may include a hospital tour.
 - e. What to expect on admission.
2. Discuss what to bring to the hospital.
 - a. Labor plan
 - b. Clothing for self and baby
3. Obtain a car seat in advance.

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"](#) and/or ["TO - Tobacco Use"](#).**
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 ["FASD - Fetal Alcohol Syndrome"](#).**
3. Refer to community resources as available or appropriate.

PN-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of the female reproductive system and breasts.
2. Discuss the changes to anatomy and physiology as a result of pregnancy.

- a. 0-16 Weeks - The patient:
 - i. might feel tired during this time - get all the needed rest
 - ii. might feel nauseated - try eating smaller meals
 - iii. might have the urge to urinate often
 - iv. might have tender breasts
 - b. 17-24 Weeks - The patient:
 - i. will start to look pregnant
 - ii. will start to feel the baby move
 - iii. will hear the baby's heartbeat
 - iv. will change the center of gravity, thus might lose her balance easily, so be very careful not to fall
 - v. will experience discomforts related to pregnancy - refer to self-help measures
 - c. 25 to 31 weeks - The patient:
 - i. may have weight increase notably toward the end of the second trimester (28 weeks)
 - ii. may consider weight guidelines
 - d. 32-34 weeks - The patient will:
 - i. experience the urge for frequent urination will return because her enlarged uterus presses on her bladder
 - ii. have the hormones soften her hip joints in order to prepare for delivery
 - iii. have the large uterus change her center of gravity - take special care to prevent falls
 - e. 35+ Weeks - The patient may:
 - i. get tired
 - ii. have contraction - Braxton Hicks contractions are irregular in their timing and don't get closer together or more intense and usually do not mean she is in labor
 - iii. not sleep well
 - f. Postpartum - The patient might experience:
 - i. being tired - this is normal
 - ii. having baby blues
 - iii. refer to **"PP - Postpartum"**
3. Discuss the impact of these changes on the patient's health or well-being.

PN-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components that may take place during pregnancy.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of pregnancy that requires a change in lifestyle. Discuss emotional change:
 - a. 0-16 Weeks - The patient might:
 - i. be concerned about herself and the changes taking place - this is normal
 - ii. have mixed feelings about the pregnancy
 - b. 17-24 Weeks - The patient might:
 - i. have decided how she feels about this pregnancy
 - ii. start thinking of the baby as a person
 - c. 25-31 weeks - The patient might:
 - i. start thinking of the baby's needs as her own
 - ii. start thinking about what she will need for the baby
 - d. 32-34 weeks - The patient might:
 - i. start thinking more about labor
 - ii. start thinking more about how she is going to care for the baby
 - e. 35+ weeks - The patient might:
 - i. start to feel “ready” for labor
 - ii. start looking forward to caring for her baby
 - iii. feel some anxiety about labor
 - f. Postpartum - The patient might have:
 - i. Additional stressors:
 - (1) physical changes and complications
 - (2) changes in family roles
 - (3) newborn needs
 - (4) changes in parents’ relationship
 - ii. Some emotional upset, baby blues, 3-5 days after birth that should not last more than a few days. If she continues to have feeling of anger, anxieties, or worry, tell her nurse or doctor.

2. Discuss that pregnancy is a state of hormonal flux and may result in rapid and unpredictable mood swings. Explain that although some emotional changes may be normal, others may require medication and/or other forms of treatment.
3. Discuss any pre-existing depression or other mental health conditions in the patient or the patient's family. Instruct the patient to report any changes related to pre-existing depression.
4. Discuss the signs and symptoms of post-partum depression. Refer to a mental health agency or provider. **Refer to ["PDEP - Postpartum Depression"](#).**

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 should prompt an immediate evaluation by a provider. 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. Instruct mother in counting fetal movement.
4. Emphasize to the patient that hypertension in pregnancy 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-HTNP Hypertension in Pregnancy"](#).**
5. Discuss complications from prior pregnancies and any factors and/or behaviors that may make this pregnancy high risk.
6. Discuss that pregnant women are at higher risk for Deep Vein Thrombosis. **Refer to ["DVT-P Prevention"](#).**

PN-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 health and wellness during pregnancy.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs during pregnancy. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.
3. Explain that the use of a cradle board is not a substitute for a car seat.

PN-DC DENTAL CARE

OUTCOME: The patient/family will understand how maternal oral hygiene affects pregnancy.

STANDARDS:

1. Emphasize the importance of an oral exam and treatments before the birth of the infant.
2. Discuss that dental caries and other oral diseases are common and associated with complications for women and infants, including pre-term labor.
3. Discuss the necessity of adequate calcium in the diet of prenatal patients to prevent calcium loss from bones and teeth.

PN-DM PREGNANCY IN PRE-EXISTING DIABETES

OUTCOME: The patient/family will understand how pre-existing diabetes can affect pregnancy.

STANDARDS:

1. Discuss blood sugar control at the time of conception and possible negatives outcomes due to hyperglycemia (i.e., birth defects, macrosomia, spontaneous abortions, or fetal death).
2. Discuss the management of pre-existing diabetes management by:
 - a. self blood glucose monitoring
 - b. medication
 - c. individualized meal plan
 - d. physical activity
3. Emphasize that prenatal care for future pregnancies should begin prior to conception for early glucose control. Consider use of birth control for reproductive planning. **Refer to [“WH-PCC Pre-Conception Care”](#).**

4. Explain that blood glucose control may be more difficult to achieve in the third trimester due to hormonal changes that elevate blood glucose.
5. Emphasize the need for follow-up care in the post partum period to monitor blood glucose as recommended.

PN-DV DOMESTIC VIOLENCE

OUTCOME: The patient/family will understand implications of domestic violence in pregnancy.

STANDARDS:

1. Discuss the risk of death (maternal or fetal) from domestic violence.
2. Discuss abusive/violent behaviors in the patient's environment.
 - a. Explain co-dependency as it relates to domestic violence.
 - b. Identify risk factors and "red flag" behaviors related to domestic violence, e.g., belittling, demeaning, humiliating, controlling behaviors, or physical, emotional, or sexual abuse.
 - c. Discuss the role of alcohol and substance abuse as it relates to domestic violence.
 - d. Explain that the natural course of domestic violence is one of escalation and that without intervention it will not resolve.
3. Discuss the availabilities of shelters and other support options available in the patient's area. Make referrals as appropriate.
4. Assist in developing a safety plan that will protect all people in the environment of violence.

PN-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity during pregnancy.

STANDARDS:

1. Discuss medical clearance issues and use of appropriate footwear for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.

4. Discuss the appropriate frequency, intensity, time, and type of activity. As pregnancy progresses, the center of balance may change, and it may be necessary to modify the type of exercise.
5. Refer to community resources as appropriate.

PN-FASD FETAL ALCOHOL SPECTRUM 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 FASD. Refer to ["FASD - Fetal Alcohol Syndrome"](#).
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. Emphasize the importance of follow-up care. Prenatal visits are a series of appointments related to stages of gestation. The recommended follow up for an uncomplicated pregnancy is:
 - a. First seven months - once a month
 - b. Eighth month - twice a month
 - c. Ninth month - every week
2. Discuss the procedure and process for obtaining follow-up appointments.
 - a. Emphasize that all prenatal appointment should be kept.
 - b. Emphasize that she should have her provider's / clinic name and phone number with her at all times.
3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate medical emergency contact information to a provider. In an emergency go to the Emergency Room if the provider cannot be reached.
 - a. Blood or any fluid from vagina

- b. Unpleasant odor or unusual vaginal discharge
 - c. Swelling of the face or fingers
 - d. Bad or long headache
 - e. Dizziness/fainting
 - f. Cloudiness, blurry vision or spots before eyes
 - g. Problems breathing
 - h. Chest pain
 - i. Stomach / abdominal pain
 - j. Frequent nausea and vomiting
 - k. Chills or fever
 - l. Painful urination
 - m. Baby moves less
 - n. Regular rhythmic contraction
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 during each trimester.

STANDARDS:

1. Explain the conception process, the implantation, and the cell division, as appropriate. Discuss the functions of the placenta, the amniotic sac, and the umbilical cord, as appropriate.
2. Give a basic overview of the unborn infant's growth and development.
 - a. 0-16 Weeks
 - i. 6 weeks - brain and major organs developing
 - ii. 6 weeks - eyes formed
 - iii. 6-7 weeks - heart seen on ultrasound
 - iv. 7 weeks - muscles develop
 - v. 8 weeks - baby can move
 - vi. 8-9 weeks - ears forming
 - vii. 12 weeks - toes and fingers formed
 - viii. 15 weeks - lanugo, fine hair forming over body

- b. 17-24 Weeks
 - i. 17 weeks - patient can feel the baby moving
 - ii. 20 weeks - scalp hair forming
 - iii. 24 weeks - vernix, greasy skin covering forming
- c. 25-31 weeks
 - i. 27 weeks - baby gains the most weight the last 13 weeks
 - ii. 29 weeks - fat layer forming
- d. 32-34 weeks
 - i. 32 weeks - baby growing rapidly
 - ii. If the baby is born early (premature) it has a good chance of doing well
- e. 35+ weeks
 - i. 36 weeks - kidneys mature
 - ii. 37 weeks - lungs mature
 - iii. 40 weeks - estimated date of delivery
- f. Postpartum - **Refer to [“CHI - Child Health - Infant \(2-12 Months\)”](#)**

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. Consider use of birth control for reproductive planning. **Refer to [“WH-PCC Pre-Conception Care”](#).**
5. Explain that blood glucose control may be more difficult to achieve 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 and screen for diabetes.

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 after delivery, newborn blood testing may detect other disorders otherwise not detected.
3. Explain that not all patients are at equal risk for these conditions.
4. Refer appropriate patients to a physician or other provider for further evaluation.

PN-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding prenatal care.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding prenatal care and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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). Explain that HIV testing is a routine part of prenatal care.
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-HTNP HYPERTENSION IN PREGNANCY

OUTCOME: The patient/family will understand will understand the risk, symptoms, and treatment of hypertension in pregnancy 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 hypertension in pregnancy may be asymptomatic or may be accompanied by warning signs (persistent swelling, persistent headaches, visual changes, abdominal pain, 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.
6. Explain the need for close monitoring, i.e., ultrasound and kick counts.

PN-IB INSURANCE AND BENEFITS

OUTCOME: The patient/family will understand healthcare services and resources available as it relates to insurance and benefits.

STANDARDS:

1. Explain that many individuals qualify for direct payments and/or reimbursement for healthcare and related costs from certain programs.
2. Explain that direct payments include services that:
 - a. Are provided at the health care facility at no cost to the patient.
 - b. Are provided at other health care facilities through contract health services.
 - i. Contract services are services that Indian Health Systems facilities cannot always provide.
 - ii. They may require a referral to non-Indian Health Systems facilities.
3. Explain that in addition to Indian Health Systems, the other available programs include:
 - a. Medicare: a national healthcare program that covers people 65 years of age and older, individuals younger than 65 who are disabled or with end stage renal disease, and retired railroad employees.
 - i. Medicare Part A: Inpatient hospital services, skilled nursing facilities, home health and hospice care.

- ii. Medicare Part B: Outpatient hospital services, doctors, certain medical equipment and other items not covered under Part A.
 - iii. Medicare Part D: Prescription medication and Medication Therapy Management (MTM) service coverage.
- b. Social Security Disability Insurance
- c. State Children's Health Insurance Programs (SCHIP)
- d. Supplemental Security Income (SSI)
- e. Veterans Administration (VA)
- f. Medicaid that provides resources to help pay for medical and long-term care assistance
- g. Private Health Plans
- h. Women, Infants, and Children (WIC)
- i. State/federal aid for disabled children (Waiver Program)
- j. Temporary Assistance for Needy Families (TANF)
4. Explain that a Benefits Coordinator is knowledgeable about federal and state programs and is a resource to help a patients determine program eligibility
5. Review and explain applications for identifiable services.
6. Explain that Indian Health Systems services can be enhanced due to revenue collected when a patient enrolls in additional health care resource.

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-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/father/significant other/family will understand lifestyle adaptations necessary during pregnancy.

STANDARDS:

1. Discuss lifestyle adaptations specific to the father's/significant other's role in the pregnancy.
 - a. Suggest that the father / significant other go to prenatal clinic visits.

- b. Suggest that the father / significant other make the lifestyle change such as a healthy diet, stop smoking, drinking or taking non- prescribed drugs if applicable, so that it will be easier for the expectant mother and family to do the same.
 - c. Suggest that the father /significant other help with household chores and child care so the expectant mother can get some rest. After the baby is born it is important for the father /significant other help care for the baby.
 - d. Suggest that the father /significant other read about pregnancy and go to childbirth classes to find out how to help during labor and delivery.
 - e. Discuss that there may less leisure time spent together and that there may be relationship changes that need to be made. Work to minimize any conflict that these expected changes bring.
 - f. Suggest the father /significant other be emotionally supportive - take time to listen and talk about the changes that are taking place.
2. Discuss that sibling rivalry and how to prepare siblings for the addition of the baby. Explain that a new baby needs lots of attention and can cause older children to feel less loved.
 3. Discuss that children can get angry and act out or act “babyish” but remember they are not bad; they may be trying to say they want attention too. Explain that babies sleep and cry a lot, cannot play games or talk, and needs everything done for them. Spend special one-on-one time with the children and allow them to participate caring for the baby.
 4. Discuss lifestyle adaptations and responsibilities to taking care of herself and her growing child such as regular prenatal care, rest, good physical hygiene, and a positive self-image.
 5. Discuss the following relief measures for the discomforts of pregnancy:
 - a. Nausea/Vomiting/Indigestion: Try eating small frequent meals, avoiding fatty and spicy foods, drinking fluids between meals, and laying down right after a large meal.
 - b. Leg cramps/ swollen feet/ varicose veins: Wear supportive low heel shoes, wear support stockings, elevate feet, change positions often, and avoid high salt foods.
 - c. Constipation/ hemorrhoids: Eat more whole grains, fruit and vegetables, increase fluids, practice Kegal exercises, take sitz baths, and walk.
 - d. Backache: Use support hose, change positions often, squat rather than bend over, and avoid lifting heavy objects.
 - e. Dizzy Spells: Avoid prolonged standing, delaying meals, and overheating, get up slowly, and increase fluids.
 - f. Muscle/ ligament pain in abdomen: Avoid over extension, change positions often, and empty bladder often.

- g. Frequent urination: Limit fluids after dinner to help cut down on bathroom visits during the night.
 - h. Headaches: Get plenty of rest and avoid skipping or delaying meals, reduce stress, use warm compress, do neck and shoulder exercises.
 - i. Emotional ups and downs: Hormone balance changes during pregnancy; this may cause emotional changes.
6. Discuss sex during each trimester of pregnancy. Encourage the patient to ask questions.

PN-M MEDICATIONS

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

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

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 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 benefits of healthy eating habits.
 - a. Explain the purpose of appropriate weight gain in pregnancy. Refer to Institute Of Medicine guidelines for recommendations for Total and Rate of Weight Gain During Pregnancy, by Pre-pregnancy BMI.
 - b. Explain the actions to correct constipation, nausea, vomiting, or pica.
 - c. Explain that certain types of fish should be limited due to the risk of mercury contamination (e.g., salmon, mackerel, tuna, sword fish).
 - d. Explain that soft cheeses such as feta, Brie, Camembert, Roquefort, and Mexican soft cheeses may be contaminated with Listeria.
 - e. Explain all meats, eggs, and fish must be fully cooked before eating.
 - f. Encourage adequate calcium intake and calcium sources (e.g., milk products, calcium supplements). **Refer to ["OS-N Nutrition"](#)** for other sources of calcium. Discuss the importance of taking prenatal vitamins and folate.
 - g. Encourage liberal intake of water.
2. Encourage a limited intake of artificial sweeteners and other foods or beverages sweetened by these products.
3. Discuss supplemental food programs (e.g., WIC, food distribution/commodity programs, food stamps).
4. Refer patients with GDM or diabetes in pregnancy to a registered dietitian for an individualized meal plan.

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. Pre term labor is defined at less than 37 weeks gestation.
2. Emphasize the importance of seeking immediate medical attention for any abnormal sensations/symptoms especially if they occur at regular intervals (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

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 that balance may be affected by pregnancy, increasing the risk for falls.
3. Discuss the dangers of fetal overheating in relation to hot baths, Jacuzzis, sweat lodges, heating pads, etc.
4. Discuss the dangers of eating raw meats, working in the garden without gloves, changing cat litter. Discuss the importance of washing hands after working with dirt or cat litter. Have someone help with these tasks.
5. Discuss domestic violence and assist in developing a safety plan to protect all people in the environment of violence. **Refer to ["PN-DV Domestic Violence"](#).**

6. Teach the patient to inform all healthcare providers of the pregnancy prior to obtaining treatment, e.g., x-rays, medications.

PN-SHS SECOND-HAND/THIRD-HAND SMOKE

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

STANDARDS:

1. Define “passive smoking” and ways in which exposure occurs, e.g., smoldering tobacco, exhaled smoke. Third-hand smoke is defined as residue in carpet, upholstery, and clothing.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, carcinogens.
3. Explain the detrimental effects of second-hand smoke.
 - a. 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.
 - b. 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.
4. Discuss that having household members smoke outside and removing smoke contaminated clothing may decrease exposure to second-hand smoke.
5. Encourage smoking cessation or at least never smoking in the home or car. **Refer to [“TO-OT Quit”](#).**
6. Explain that tobacco exposure is harmful and should be assessed at every encounter. Refer to the 5A approach for tobacco screening (Ask, Advise, Assess, Assist, Arrange).

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 the social services available.

STANDARDS:

1. Discuss the patient's living situation including access to adequate housing, electricity, refrigeration, sanitation, running water, and having adequate nutritional foods and food security.
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 Indian Health Service/Tribes/Urban (I/T/U) programs may not be able to meet all of the patient's needs and the patient may need to access multiple sources.
4. Discuss adoption and abortion, as appropriate. Refer to Community Resources, Behavioral Health, and/or Social Services as appropriate.
5. Discuss miscarriage and stillbirth. Refer to community resources. **Refer to [“PNL - Perinatal Loss”](#).**

PN-STI SEXUALLY TRANSMITTED INFECTIONS

OUTCOME: The patient/partner will understand the risk factors, transmission, symptoms, and complications of sexually transmitted infections during pregnancy.

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. 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"](#) and ["HIV - Human Immunodeficiency Virus"](#) as appropriate.

PN-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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
 - g. Sudden Infant Death Syndrome (SIDS)
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 and exposure should be assessed at every encounter. Encourage tobacco cessation. Refer to the 5A approach for tobacco screening (Ask, Advise, Assess, Assist, Arrange).
6. Refer to ["TO - Tobacco Use"](#).

PN-VBAC VAGINAL BIRTH AFTER CESAREAN SECTION

OUTCOME: The patient/labor partner/family will understand that VBAC may be an option.

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.
4. Explain the importance of adhering to the labor plan.

PU - Pressure Ulcers

PU-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

PU-C COMPLICATIONS

OUTCOME: The 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 that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

PU-DP DISEASE PROCESS

OUTCOME: The patient/family will understand what pressure ulcers are and the 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 will pose a risk to infection.

PU-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
2. Demonstrate and participate in the return demonstration of the safe and proper use, care and cleaning of the equipment as appropriate.
3. 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.
4. Emphasize the importance of not tampering with any medical device.

PU-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

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 on 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

PU-MNT MEDICAL NUTRITION THERAPY

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

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: The parents/family will understand 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.
3. Refer to a Registered Dietitian (RD).

PU-P PREVENTION

OUTCOME: The patient/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. Instruct family not to massage reddened skin over bony prominences. This does not increase circulation and can further damage tissue.
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. 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.
4. 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.

PU-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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
5. Explain non-pharmacologic measures that may be helpful with pain control.

PU-PRO PROCEDURES

OUTCOME: The patient/family will understand the possible procedure(s) that may be performed to treat the pressure ulcer. The patient/family will further understand the risks and benefits of the procedure, the alternatives to the proposed procedure, and the risks of refusal of the proposed procedure.

STANDARDS:

1. Discuss the indications, risks, and 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

PU-SCR SCREENING

OUTCOME: The patient/family will understand the reason and the 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/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

PU-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be performed based on the test results. The patient/family will further understand 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. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

PSR - Psoriasis

PSR-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

PSR-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to psoriasis.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with psoriasis as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with psoriasis, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).**
6. Refer to a mental health agency or provider.

PSR-C COMPLICATIONS

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

STANDARDS:

1. Discuss common complications of psoriasis.
2. Describe the signs/symptoms of common complications of psoriasis.
3. Discuss the psychological complications of psoriasis. **Refer to [“PSR-BH Behavioral and Emotional Health](#).**

4. Discuss the increased risk of secondary bacterial infection especially in person with immunocompromise or diabetes.
5. Discuss that psoriasis of palpebral conjunctiva (inner eyelid) can cause multiple ocular complications.
6. Explain that later or advanced 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

PSR-DP DISEASE PROCESS

OUTCOME: The patient will understand the basic pathophysiology, symptoms, and prognosis of psoriasis.

STANDARDS:

1. Explain that psoriasis is a skin disease that causes dry, white to silver patches on the skin. It can show up on any part of the body; usually, it occurs on the elbows, knees, scalp, or torso. Psoriasis is incurable, not contagious, and requires lifelong treatment with remission and flare-ups.
2. Explain that a variety of factors can induce a flare-up of psoriasis, including:
 - a. Emotional stress
 - b. Injury to the skin
 - c. Reaction to certain drugs
 - d. Some types of infection (e.g., Streptococcal)
 - e. Dry skin
3. Discuss that psoriasis is an autoimmune disorder in which 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 which can manifest in one of the following forms:
 - 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 with white or silver scales 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.

PSR-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding Psoriasis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding Psoriasis and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

PSR-L LITERATURE

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

STANDARDS:

1. Provide the 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.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

PSR-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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. Explain that the need for adequate hydration.
2. Explain the need for vitamin and mineral supplementation, especially vitamins D and A and Zinc.
3. Explain omega-three fatty acids are beneficial in reducing inflammation.
4. Refer to a registered dietitian for MNT 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, sunburns, 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](#).**

PSR-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, 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 is expected after the procedure.

3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

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, 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.

PSYD - Psychotic Disorders

PSYD-C COMPLICATIONS

OUTCOME: The patient/family will understand the possible complications related to psychotic disorders.

STANDARDS:

1. Explain that individuals with psychotic disorders often have shorter life expectancies for many reasons, including risk of suicide and non-compliance with treatment. Explain that the complications are most serious with schizophrenia and will be less pronounced in the others, including Schizoaffective and Delusional Disorders.
2. Discuss that individuals diagnosed with psychotic disorders may have unpredictable, erratic and potentially dangerous behavior, including angry outbursts and verbal and/or physical threats. This often adversely affects family involvement in care of the patient and can lead to legal involvement.
3. Explain that the chronic nature of most psychotic disorders often impedes normal functioning and often progresses toward disability, wherein many individuals may be unable to hold a job for sustained periods, have difficulties with self-care, have their schooling disrupted, and relinquish their social activities in favor of isolation.
4. Explain that several abnormalities have been noted in those diagnosed with Schizophrenia, but have not been substantiated in other psychotic disorders, including:
 - a. Brain structure anomalies: enlargement of the ventricular system, prominent Sulci in the cortex, decreased temporal and hippocampal size, increased size of the basal ganglia, and decreased cerebral size.
 - b. Abnormal cerebral blood flow or glucose utilization in specific brain regions.
 - c. Neuropsychological abnormalities: difficulty in changing response set, focusing attention, and formulating abstract concepts.
5. Explain that individuals diagnosed with schizophrenia or other serious psychotic disorders are sometimes physically awkward, and may develop neurological “soft signs,” such as poor coordination, right/left confusion, and motor abnormalities, such as sniffing, grunting, and tongue clucking, although some may be exacerbated by the side effects from anti-psychotic medications.
6. Explain that individuals diagnosed with psychotic disorders often have other associated problems, including Substance-Related Disorders (**refer to [“AOD - Alcohol and Other Drugs](#)**), and may be preceded by Schizotypal, Schizoid, or Paranoid Personality Disorders (**refer to [“PERSD - Personality Disorder](#)**). It is not clear whether these personality disorders are separate or simply prodromal to the psychosis. They may also develop social anxieties or phobias (**refer to [“PHOB - Phobias](#)**).

PSYD-CM CASE MANAGEMENT

OUTCOME: The patient/family will understand the importance of integrated case management in treating psychotic disorders.

STANDARDS:

1. Discuss roles and responsibilities of each member of the care team including the patient, family/caregiver, group home staff members, 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”](#).

PSYD-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

PSYD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of the psychotic disorder under consideration.

STANDARDS:

1. Explain that the active phase of a psychotic disturbance may be characterized as falling into two broad categories, none of which are etiologically related to a general medical condition or the direct effects of a substance:
 - a. Positive Symptoms reflect an excess or distortion of normal functions, including delusions, auditory and/or visual hallucinations, disorganized, incoherent, or derailed speech, and/or grossly disorganized or catatonic behavior (the latter usually in schizophrenia only).

- b. Negative Symptoms appear to reflect a diminution or loss of normal functions and accounts for a substantial degree of morbidity associated with the disorder, including affective flattening, alogia (poverty of speech manifested by brief, laconic, empty replies), diminution of thoughts, and avolition, as characterized by an inability to initiate and persist in goal-directed activities.
2. Explain the essential features of the specific disorder under consideration:
 - a. **Schizophrenia** is a chronic disturbance that includes at least 1 month of active phase symptoms (see #1 above) with high potential for recurrences, and are also usually associated with marked life-long social and occupational dysfunction, as well as a range of cognitive and emotional dysfunctions.
 - b. **Schizophreniform Disorder** is the initial diagnosis for a first psychotic break usually before the age of 25 years that lasts from one to six months before schizophrenia is formally diagnosed or ruled out based on a diagnosis of a general medical disorder or drug effect that explains the psychotic symptoms.
 - c. **Schizoaffective Disorder** is a chronic disturbance in which a mood episode and active-phase symptoms of schizophrenia occur together and were preceded or followed by at least two weeks of delusions or hallucinations without prominent mood symptoms.
 - d. **Delusional Disorder** is characterized by at least one month of non-bizarre delusions without other active phase symptoms of schizophrenia.
 - e. **Brief Psychotic Disorder** includes active psychotic symptoms that remit within one month.
 - f. **Shared Psychotic Disorder** is a disturbance that develops in an individual who is influenced by someone else who has an established delusion with similar content.
 - g. **Substance-Induced Psychotic Disorder** is a disturbance in which psychotic symptoms developed during or within one month of substance intoxication or withdrawal, and that symptoms did not persist after a significant period of time following the cessation of acute intoxication or withdrawal (**refer to [“AOD - Alcohol and Other Drugs”](#)**). This diagnosis requires evidence from laboratory findings, history, and physical examination.
 - h. **Psychotic Disorder Not Otherwise Specified (NOS)** is included for classifying presentations that do not meet criteria for any of the specific Psychotic Disorders or psychotic symptomology about which there is inadequate or contradictory information.
 3. Explain that the onset of psychotic disorders may be abrupt, but the majority display some type of prodromal phase manifested by the slow and gradual development of various signs and symptoms, e.g., social withdrawal, deterioration in hygiene/grooming, unusual behavior.
 - a. Explain that the course of the disorders may be variable, with some individuals displaying exacerbations and remissions, while others remain chronically ill.

- b. Explain that functioning is typically below that which had been achieved before the onset of symptoms.
 - c. Explain that complete remission, i.e., a return to full premorbid functioning, is not common.
 - d. Explain some patients may have a relatively stable course, whereas others show a progressive worsening associated with severe disability.
4. Explain that prodromal and residual periods manifest between active phases, and are characterized mainly by negative symptoms, but at times may also include a mild form of the positive symptoms, such as understandable but digressive speech or odd beliefs that do not reach delusional proportions.
 5. Discuss associated features including inappropriate affect, such as laughter out of context or silly facial expressions, anhedonia, abnormal psychomotor activity, such as rocking or pacing, distractibility and difficulty concentrating, memory impairment, lack of insight, non-compliance with treatment, somatic concerns, odd mannerisms, and stereotyped behavior.

PSYD-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in maintaining health with psychotic disorders.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

PSYD-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

PSYD-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - a. Be willing to change.
 - a. Set small, realistic, sustainable goals.
 - a. Practice new knowledge.
 - a. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

PSYD-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of individuals with psychotic disorders.

STANDARDS:

1. Explain the home management techniques, including frequent observation, the provision of meals, and products to encourage recreational activities.
2. Discuss the monitoring and implementation of hygiene measures.
3. Discuss signs of agitation, ways of dealing with it, and safety protocols.
4. Refer to community resources or support groups, as appropriate.

PSYD-HY HYGIENE

OUTCOME: The patient/family will understand the importance of monitoring personal routine hygiene.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

PSYD-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.

PSYD-L LITERATURE

OUTCOME: The patient/family will receive literature about the specific psychotic disorder.

STANDARDS:

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

PSYD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for psychotic disorders.

STANDARDS:

1. Discuss lifestyle adaptations specific to the psychotic disorder under consideration, which due to its chronic nature, often includes a third party to act as caregiver and sometimes legal guardian.
2. Discuss that family may also require lifestyle adaptations to care for the patient, including helping the patient attend to ADLs, and applying safety measures should a patient become agitated and/or potentially dangerous to self or others.
3. Explain that individuals with psychotic disorders often show marked improvement in structured settings, such as Day Treatment Programs or group homes that incorporate daily recreational, educational, social, and therapeutic activities.
4. Discuss the role of respite care or extended family members in providing a support network for the care of the patient.
5. Discuss work, family, diet, and exercise (**refer to [“PSYD-EX Exercise](#)**) adaptations that will be necessary due to the nature of anti-psychotic medications that can cause sedation and cravings for sweet food (**refer to [“PSYD-N Nutrition](#)**).
6. Refer to community services, resources, or support groups, as available.

PSYD-M MEDICATIONS

OUTCOME: The patient/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 full participation with the medication plan and that this is the patient/caregiver’s responsibility. Discuss any barriers to full participation.
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/caregiver to bring this list and pill bottles to appointments for medication reconciliation.

PSYD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for psychotic disorders.

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.

PSYD-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to psychotic disorders.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Refer to registered dietitian for MNT or other local resources as appropriate.

PSYD-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of psychotic disorders.

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. Emphasize that full participation and follow-up is critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.

6. Explain that the therapist and the patient/family/guardian will establish goals and duration of therapy together, although supportive therapy is generally recommended indefinitely for the chronically mentally ill.

PSYD-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to psychotic disorders, and the risk of suicide or other risky behavior.

STANDARDS:

1. Discuss/review the safety plan with the patient and family, including the no-harm contract and emergency procedures for worsening conditions, e.g., suicidal or homicidal ideation, decompensation, and/or inability to care for the patient.
2. Discuss the importance of psychiatric hospitalization during crises to ensure patient safety.
3. Review the local resources and phone numbers, including the police that may be utilized during a crisis, and may assist in transportation and safety compliance.

PSYD-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect on the condition and precipitate depression or agitation.
2. Explain the role of effective stress management in preventing and/or abating mood changes and/or decompensation.
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.

PSYD-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

PSYD-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options for psychotic disorders.

1. Explain that both therapy and medication is recommended for psychotic disorders because of their chronic nature.
2. Explain that medication intervention is the crucial factor for stability in psychotic disorders, and that psychotherapy usually takes on a more supportive role for chronic conditions.
3. Explain that medication and psychotherapy may also be useful in treating comorbid conditions that exacerbate the course of psychotic disorders, and may help improve quality of life.
4. Explain that therapists have different styles and orientations of therapy, and that no one approach has been shown to be more effective than others, although some styles may suit the patient better.

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 as appropriate services to assist the patient in making a living will, e.g., Social Services, Clergy, Lawyer.
4. Refer to ["ADV - Advance Directives"](#).

PL-AP **ANATOMY AND PHYSIOLOGY**

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

STANDARDS:

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

PL-BH **BEHAVIORAL AND EMOTIONAL HEALTH**

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to pulmonary disease.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with pulmonary disease as a life-altering illness that requires a change in lifestyle (refer to ["PL-LA Lifestyle Adaptations"](#)).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with pulmonary disease, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.

3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#).**
6. Refer to a mental health agency or provider.

PL-C COMPLICATIONS

OUTCOME: The patient/family will understand the 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.

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”](#).**

PL-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective. **Refer to [“PL-TO Tobacco \(Smoking\)”](#) and [“PL-SHS Second-Hand/Third-Hand Smoke”](#).**

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 O₂/CO₂ and resist infection.
3. Discuss the pathophysiology of the patient’s specific disease process. **Refer to [“ASM - Asthma”](#), [“CF - Cystic Fibrosis”](#), [“SARS - Severe Acute Respiratory Syndrome”](#), [“HPS - Hantavirus Pulmonary Syndrome”](#), [“PNM - Pneumonia”](#).**

PL-EQ EQUIPMENT

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

STANDARDS:

1. Discuss considerations specific to equipment and understand their role in the management of pulmonary diseases:
 - a. Bilevel (or continuous) positive airway pressure ventilation:
 - i. BiPAP or CPAP is delivered utilizing a tight-fitting mask over the nose and/or mouth
 - ii. Patient cooperation is vital to successful BiPAP or CPAP management
 - b. Nebulizer: Describe proper use of the nebulizer including preparation of the inhalation mixture, inhalation technique, and care of equipment. Discuss the nebulizer treatment as it relates to the medication regimen. **Refer to [“M-NEB Nebulizer”](#).**

- c. Oxygen:
 - i. Discuss the dangers of ignition sources around oxygen, e.g., cigarettes, sparks, flames.
 - ii. Emphasize that O₂ flow rate should be changed except upon the order of a physician because altering the flow rate may worsen the condition.
 - d. Peak flow meter:
 - i. 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.
 - ii. Explain how monitoring measurement of PEFR can provide an objective way to determine current respiratory function.
 - iii. 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.
2. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
 3. Demonstrate and participate in the return demonstration of the safe and proper use, care, and cleaning of the equipment, 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.

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 pulmonary rehabilitation or 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

PL-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of the disease process and will 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-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to pulmonary disease.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.

- c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

PL-IS INCENTIVE SPIROMETRY

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

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.

PL-M MEDICATIONS

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

STANDARDS:

1. Discuss the difference between bronchodilators and anti-inflammatory medications, and between short-acting relief and long-acting controller medications. **Refer to [“PL-MDI Metered-Dose Inhalers”](#) or [“M-MDI Metered-Dose Inhalers”](#).**
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 the difference between bronchodilator and anti-inflammatory (e.g., short acting relieve and long acting controller) medications.
5. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
6. 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, inhalers, 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.
3. Discuss the purpose of a spacer device. Instruct and demonstrate proper technique for spacer use. Discuss the proper care and cleaning of spacers.

PL-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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/family will understand how to modify diet to conserve energy and to promote nutritional balance.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake. Stress the importance of water intake to aid in thinning sputum.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.

5. Refer to dietitian for MNT as appropriate.

PL-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of developing pulmonary disease or complication.

STANDARDS:

1. Discuss avoiding exposures to environmental triggers, pollution, smoke.
2. Discuss the role of tobacco and the need to avoid it. **Refer to [“TO - Tobacco Use”](#).**
3. Discuss occupational and craft exposures.
4. Explain the importance of vaccinations, especially against Pneumococcus and Influenza, particularly in patients who already have a pulmonary disease. **Refer to [“IMP - Impetigo”](#) and [“FLU - Influenza”](#).**

PL-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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
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. Discuss the indications, risks, and 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. **Refer to [“PL-TX Treatment”](#).**

2. Explain the process and what is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

PL-SHS SECOND-HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Explain that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, and many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness when exposed to cigarette smoke either directly or via second-hand/third-hand smoke.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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 - Tobacco Use”](#).**

PL-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):

- a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
- a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

PL-TO TOBACCO (SMOKING)

OUTCOME: The patient/family will understand the dangers of smoking or exposure of the pulmonary patient to cigarette smoke and will develop a plan to eliminate 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"](#).

PL-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 participation in the treatment plan.
2. Discuss specific therapies that may be utilized, their own inherent risks, side effects, and expected benefits:
 - a. BiPAP or CPAP - Refer to ["PL-EX Exercise"](#)
 - b. Nebulizer - Refer to ["PL-EX Exercise"](#)
 - c. Oxygen

- d. Intubation
 - e. Mechanical ventilation
 - f. Tracheostomy
3. Explain the criteria for discontinuing certain therapies, e.g. mechanical ventilation.
 4. Discuss the importance of maintaining a positive mental attitude.

PYELO - Pyelonephritis

PYELO-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

PYELO-C COMPLICATIONS

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

STANDARDS:

1. Discuss common complications of pyelonephritis, e.g., acute kidney failure, infection around the kidney (perinephric abscess), recurrent pyelonephritis, urinary obstructions or vesicoureteral reflux, severe blood infection (sepsis). Chronic infections may occur during infancy or childhood.
2. Describe the signs/symptoms of common complications of pyelonephritis, such as shaking chills, high fever, pain in joints and muscles, and flank pain.

PYELO-CM CASE MANAGEMENT

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

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"](#).**

PYELO-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

PYELO-DP DISEASE PROCESS

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

STANDARDS:

1. Discuss pyelonephritis is a serious bacterial infection of the kidney that can be acute or chronic
2. Explain that pyelonephritis is often preceded by bladder infections.
3. Explain that the symptoms may include: shaking chills, high fever, pain in joints and muscles, and flank pain.

PYELO-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

PYELO-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

PYELO-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

PYELO-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:

- a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

PYELO-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of pyelonephritis.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

PYELO-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to pyelonephritis.

STANDARDS:

1. Discuss the importance of hand-washing control, especially in relationship to food preparation/consumption, child care, and toilet use.
2. Review the importance of bathing, paying special attention to the pubic hair area. Keep genital area clean:
 - a. For women, explain that wiping from front to back helps reduce the chance of introducing bacteria from rectal area to the urethra.
 - b. For men, explain the need to retract the foreskin when bathing.
3. Explain that urinating immediately after sexual intercourse may help eliminate any bacteria that may have been introduced during sexual activity.

PYELO-L LITERATURE

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

STANDARDS:

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

PYELO-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

PYELO-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to pyelonephritis.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss drinking more fluids, as appropriate for age, weight, environment, and comorbid conditions. This encourages frequent urination and flushes bacteria from the bladder.
4. Explain that intake of moderate amounts of cranberry juice may prevent UTI in non-chronically ill individuals.

PYELO-P PREVENTION

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

STANDARDS:

1. Discuss strategies to prevent urinary tract infections. Refer to ["PYELO-HY Hygiene"](#).

2. Explain prompt and complete treatment of lower urinary tract infections may prevent development of many cases of pyelonephritis. Chronic or recurrent urinary tract infection should be treated thoroughly.
3. Explain that intake of moderate amounts of cranberry juice may prevent UTI in non-chronically ill individuals.

PYELO-PRO PROCEDURE

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 of 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 for the procedure.
4. Discuss pain management as appropriate.

PYELO-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

PYELO-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

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. Explain that certain positioning of patient/equipment may be required for imaging, as appropriate.

XRAY-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in radiology/nuclear medicine.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

XRAY-L LITERATURE

OUTCOME: The patient/family will receive literature about radiology/nuclear medicine.

STANDARDS:

1. Provide the 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

XRAY-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.

5. Explain non-pharmacologic measures that may be helpful with pain control.

XRAY-PRO PROCEDURES

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

STANDARDS:

1. Discuss the indications, risks, and 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.
6. Explain that some procedures may require chaperones.

XRAY-S SAFETY

OUTCOME: The patient/family will understand the safety procedures used to protect the patient and staff.

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.
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(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered and method of imaging, e.g., MRI, CT scan, ultrasound, EKG, etc. Explain as appropriate:
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s), e.g., fasting
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

REACT - Reactive Attachment Disorder

REACT-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications associated with reactive attachment disorder.

STANDARDS:

1. Explain that Reactive Attachment Disorder (REACT) is a serious disorder, which without treatment, may progress to violence toward self and others, destruction of property, and school problems.
2. Explain that reactive attachment disorder, if left untreated, may develop into other conduct disorders (refer to [“COND - Conduct Disorder”](#)), and eventually adulthood Personality Disorders (refer to [“PERSD - Personality Disorder”](#)), mood disorders, and legal problems.

REACT-CM CASE MANAGEMENT

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

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”](#).

REACT-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

REACT-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and signs of reactive attachment disorder.

STANDARDS:

1. Explain that the essential features of reactive attachment disorder is the markedly disturbed and developmentally inappropriate social relatedness in most contexts that begins before the age of 5 years, which includes:
 - a. **Primarily Inhibited Type** in which the child shows excessively inhibited, hypervigilant, or highly ambivalent behavior, e.g., frozen watchfulness, or resistance to comforting or touch.
 - b. **Disinhibited Type** in which the child shows a pattern of diffuse attachments as manifest by indiscriminate sociability, e.g. excessive familiarity with relative strangers and lack of selectivity in attachment figures.
2. Discuss the elements of pathogenic care that contributes to and is presumed to be responsible for the child's dysfunction, including:
 - a. persistent disregard for the child's basic emotional needs for comfort, stimulation, and affection
 - b. persistent disregard for the child's basic physical needs
 - c. repeated changes of primary caregiver that prevents the formation of stable attachments
3. Explore the behavioral features that may be associated with reactive attachment disorder, including oppositional behavior, frequent and intense anger, outbursts, manipulative or controlling behavior, little or no conscience, destructive behavior to self, others, and property, cruelty to or killing animals, gorging or hoarding food, and preoccupation with fire, blood, or violence.
4. Explain that reactive attachment disorder may be associated with developmental delays, Feeding Disorders of Infancy or Early Childhood, Pica, or Rumination Disorder.

REACT-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in treating and caring for a child with reactive attachment disorder.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.

3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

REACT-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

REACT-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding reactive attachment disorder.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding reactive attachment disorder and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

REACT-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.

3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

REACT-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to reactive attachment disorder.

STANDARDS:

1. Discuss the importance of washing in infection prevention.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

REACT-L LITERATURE

OUTCOME: The patient/family will receive literature about reactive attachment disorder.

STANDARDS:

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

REACT-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for coping with reactive attachment disorder.

STANDARDS:

1. Discuss lifestyle adaptations specific to caring for a child with reactive attachment disorder.

2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

REACT-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

REACT-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for treating reactive attachment 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.

REACT-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to reactive attachment disorder.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

REACT-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of developing reactive attachment disorder or associated problems.

STANDARDS:

1. Discuss strategies to prevent dangerous behaviors or complications of reactive attachment disorder, such as constant supervision and structure, and following the treatment plan, including medications. **Refer to [“REACT-PA Parenting”](#).**
2. Explain that the risk of developing reactive attachment disorder might be reduced by being actively engaged with the child and caregivers and taking parenting skills classes for education regarding attachment issues, understanding baby’s verbal and non-verbal cues, and teaching children appropriate feeling expression.

REACT-PA PARENTING

OUTCOME: The patient/family will understand parenting skills necessary to treat reactive attachment disorder.

STANDARDS:

1. Emphasize the importance for parents to learn strategies for building attachment and close, physical comfort for the child.
2. Discuss the methods for appropriate parenting at home, including the appropriate use of rewards and consequences.

3. Discuss the physical, emotional, and cognitive needs of the child based on age and level of development.
4. Emphasize the importance communicating in a way that the child understands.
5. Discuss the methods for providing emotional support and unconditional assistance to the child.
6. Refer the family to mental health services/ family counseling if the family is becoming overwhelmed.

REACT-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of reactive attachment disorder.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

REACT-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to reactive attachment disorder.

STANDARDS:

1. Discuss the consequences of dangerous acts, such as assault and fire-setting.
2. Discuss/review the safety plan with the patient and family, including the no-harm contract and emergency procedures should the condition exacerbate, or should agitation, tension, or suicidal/homicidal ideation arise.
3. Review the local resources and phone numbers, including the police, who may be utilized during a crisis, and may assist in transportation and safety compliance.

REACT-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in coping with the symptoms of reactive attachment disorder.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in treating reactive attachment disorder.
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.

REACT-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

REACT-TX TREATMENT

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

STANDARDS:

1. Explain the treatment for reactive attachment disorder is a long term challenge for parents and caregivers, as well as treatment team, and may involve a combination of psychotherapy and medication. Explain that parental participation in the treatment is critical to a good outcome (**refer to [“REACT-PA Parenting”](#)**).
2. Explain that therapists have different styles and orientations for treating reactive attachment disorder, and that some styles may suit the patient and family better than others. Explain the strategies, including:
 - a. Individual Psychological Counseling
 - b. Education of parents and caregivers about the condition
 - c. Parenting Skills classes
 - d. Family therapy
 - e. Special Education services
 - f. Residential or inpatient treatment for children with more serious problems, or at risk of harm to self and others
3. Explain that medications may also be prescribed to treat comorbid conditions, such as depression and aggressive behavior (**refer to [“REACT-M Medications”](#)**).
4. Explain that the treatment plan will be made by the parents and the treatment team after reviewing the available options. Explain that treatment for reactive attachment disorder may vary according to the patient’s life circumstances, severity of the condition, the family’s participation in the intervention, and available resources.

RH - Reactive Hypoglycemia

RH-C **COMPLICATIONS**

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

STANDARDS:

1. Discuss common complications of reactive hypoglycemia.
2. Describe the signs/symptoms of common complications of reactive hypoglycemia.

RH-CM **CASE MANAGEMENT**

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

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”](#).**

RH-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining adequate glucose levels. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

RH-DP **DISEASE PROCESS**

OUTCOME: The patient/family will understand the disease process of reactive hypoglycemia.

STANDARDS:

1. Explain that reactive hypoglycemia can cause the blood sugar to drop in a postprandial state.
2. Explain that the signs/symptoms of low blood sugar include shakiness, dizziness, headache, hunger, nausea, blurred vision, sweating, lack of concentration, heart palpitations, irritability, fatigue, inability to sleep, and unconsciousness. Symptoms generally appear 1.5 to 5 hours after eating foods high in carbohydrates.
3. Explain that this condition may be caused by a deficiency or increased production of hormones that regulate blood sugar.
4. Emphasize that there is no cure for reactive hypoglycemia, but can be managed with lifestyle changes such as healthy eating practices, regular physical activity, no tobacco use, and no alcohol.
5. Discuss the possibility of developing diabetes in the future.

RH-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

RH-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

RH-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding reactive hypoglycemia.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding reactive hypoglycemia and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

RH-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of reactive hypoglycemia.

STANDARDS:

1. Explain the home management techniques (e.g., nutrition, exercise, and home monitoring if necessary).
2. Discuss the role of support systems/family in the plan.
3. Refer to community resources, hospice, or support groups, as appropriate.

RH-L LITERATURE

OUTCOME: The patient/family will receive literature about reactive hypoglycemia.

STANDARDS:

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

RH-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for reactive hypoglycemia.

STANDARDS:

1. Discuss lifestyle adaptations specific to are the key components to preventing low blood sugar.
2. Emphasize that appropriate nutrition, regular physical activity, and blood sugar monitoring are critical components in addressing reactive hypoglycemia.

3. Discuss that the family may also require lifestyle adaptations to care for the patient.
4. Discuss ways to optimize quality of life.
5. Refer to community services, resources, or support groups, as available.

RH-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

RH-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for reactive hypoglycemia.

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.

RH-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to reactive hypoglycemia.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, planning shopping, and eating small, frequent meals and snacks.
2. Explain the importance of appropriate serving sizes, reading food labels, and selection of whole grains foods.
3. Identify techniques or strategies for eating out, social events, traditional eating practices, and family support in managing blood sugar.
4. Discuss managing food intake on sick days and with an exercise regimen to prevent low blood sugar.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

RH-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of an episode of reactive hypoglycemia and will develop a plan for risk reduction.

STANDARDS:

1. Discuss current recommendations for screening.
2. Explain that a healthy eating plan of 5-6 small meals a day will reduce the episodes of reactive hypoglycemia.
3. Discuss blood sugar monitoring and appropriate goal range.
4. Explain the importance of carrying sugar food source to use in case of meal disruption.

RH-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to reactive hypoglycemia.

STANDARDS:

1. Discuss signs and symptoms of hypoglycemia. Explain how to prevent and/or treat. Discuss operating heavy equipment/machinery, driving a vehicle, etc.
2. Discuss carrying a food source or glucose tablets at all times in the event of a reactive hypoglycemic episode.

3. Discuss the use of a medical alert device.

RH-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

RH-TX TREATMENT

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

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

RSV - Respiratory Syncytial Virus

RSV-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

RSV-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and serious complications of RSV.

STANDARDS:

1. Discuss that many children with RSV also develop an ear infection.
2. Explain that only a small number of children with RSV will need hospitalization for oxygen or IV fluids.
3. Discuss that patients with severe symptoms from RSV may have recurrent wheezing for many months after resolution of the RSV infection.

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. 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.
4. 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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 for older children and adults warm liquids may be helpful to loosen secretions in the back of the throat and relieve coughing spasms.
4. Discuss the use of thickened feeds for infants who are tachypneic to prevent aspiration.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

RSV-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to RSV.

STANDARDS:

1. Discuss appropriate hydration and caloric intake and encourage small and frequent feedings.
2. Discuss appropriate use of thickening agents to prevent aspiration in young children and infants.
3. Refer to registered dietitian for MNT or other local resources as appropriate.

RSV-NEB NEBULIZER

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
 - h. preparation of the inhalation mixture, as appropriate
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.

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 (refer to current guidelines for RSV prophylaxis).

RSV-SHS SECOND-HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Explain that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, and many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness when exposed to cigarette smoke either directly or via second-hand/third-hand smoke.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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 1711.**

RSV-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered. Explain as appropriate:
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan

- d. recommendations based on the test results

RSV-TO TOBACCO (SMOKING)

OUTCOME: The patient/family will understand the dangers of exposure of the patient with RSV to cigarette 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-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

RST - Restraints and Seclusion

RST-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological impact of using restraints and seclusion in emergency situations.

STANDARDS:

1. Discuss the potential stress, anger, fear, shame, humiliation, or other emotional reactions that are common for patients who require the use restraints or seclusion.
2. Discuss the danger of denial about the problem underlying the need for restraints or seclusion, and the importance of seeking help in accepting and coping with the problem.

RST-EQ EQUIPMENT

OUTCOME: The patient/family will be instructed on the type of restraint used or the details of the seclusion needed.

STANDARDS:

1. Explain the type of restraints to be used on the patient, and/or the physical space where the patient will be kept (**refer to [“RST-PRO Procedure”](#)**):
 - a. Hand mitts (least restrictive to prevent scratching, pulling, hitting, picking)
 - b. Hard/soft restraints (2-Point) less restrictive
 - c. Soft ties or vests (more restrictive)
 - d. Lap cushions, trays (which the patient cannot remove, more restrictive)
 - e. Hard/soft restraints (4-point) most restrictive
2. Explain that nursing assessments will be completed as policy dictates (**refer to [“RST-PRO Procedure”](#)**).
3. Explain to the patient/family the necessary conditions for early release from restraints or seclusion.

RST-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 prevention care and services.

2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

RST-L LITERATURE

OUTCOME: The patient/family will receive literature about restraints, seclusion, and their clinical justification.

STANDARDS:

1. Provide the patient/family with literature on restraints, seclusion, and prevention strategies.
2. Discuss the content of the literature.

RST-M MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of chemical restraints.

STANDARDS:

1. Discuss that a chemical restraint is a medication used to control behavior or restrict the patient's freedom of movement that is not a standard treatment for the patient's medical or psychiatric condition.
2. Discuss the name, purpose, and dosing 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.

RST-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for patients with restraints or in seclusion.

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.

RST-P PREVENTION

OUTCOME: The patient/family will understand ways to accomplish the goal of reducing or eliminating the use of restraints and seclusion.

STANDARDS:

1. Discuss the rationale for the use of restraints and seclusion to prevent injury, harm, or death to self or others that may result as a consequence of agitation, psychosis (**refer to ["PSYD - Psychotic Disorders"](#)**), delirium or dementia, Conduct Disorder (**refer to ["COND - Conduct Disorder"](#)**), Antisocial Personality Disorder (**refer to ["PERSD - Personality Disorder"](#)**), or a general medical condition.
2. Discuss the emphasis on preventing the need for restraints or seclusion whenever possible:
 - a. **Primary prevention:** preventing the need for restraints or seclusion
 - b. **Secondary prevention:** early intervention which focuses on the use of creative, least restrictive alternatives tailored to the individual to reduce the need for restraints or seclusion
 - c. **Tertiary prevention:** reversing or preventing negative consequences when, during an emergency, restraints and seclusion cannot be avoided
3. Explain the commitment to obtain feedback from each stage to inform and improve subsequent services in the use or avoidance of restraints and seclusion.

RST-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient; and may be multifaceted. **Refer to ["PM - Pain Management"](#)**.

3. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

RST-PRO PROCEDURE

OUTCOME: The patient/family will understand the proposed procedure for the use of restraints and seclusion, including the indications, complications, and alternatives.

STANDARDS:

1. Explain the policies and procedures for use of restraints and seclusion.
2. Discuss the purpose for use of restraints or seclusion, the expected duration of restraint or seclusion, the frequency of staff observation/intervention, and criteria for discontinuation.
 - a. Explain that restraints and seclusion are a last resort when less restrictive measures have been found to be ineffective to protect this the patient or others from harm.
 - b. Discuss the alternative interventions that were attempted but proved ineffective prior to the use of restraints or seclusion.
3. Explain the specific purpose for the use of restraints or seclusion:
 - a. The **medical or surgical** reason supports medical treatment.
 - b. A **behavioral health** care reason to protect the patient against injury to self or others.
 - c. A **forensic restraint** is initiated by law enforcement.
4. Explain the parameters for the use of restraints and seclusion:
 - a. Physical Space that is calm, quiet, and maximizes privacy, and assures reasonable access to bathroom and a clock
 - b. Dignity, privacy, and safety is protected, including essential clothing
 - c. Prohibited hospital practices include fear-eliciting techniques, corporal punishment, and use of mechanical restraint and seclusion
5. Explain the process for applying the procedures within an individualized care plan, which includes pre-existing conditions that may predispose the patient to greater physical or psychological risk (**refer to ["RST-S Safety"](#)**), e.g. history of assault.

RST-S SAFETY

OUTCOME: The patient/family will understand the safety risks and benefits in the use of restraints and seclusion, and methods for communicating safely with staff.

STANDARDS:

1. Discuss the potential safety benefits and the necessity for using restraints or seclusion, i.e., when used properly, it can be a life-saving and injury sparing intervention.
2. Explain the safety risks associated with the restraints or seclusion, especially for those with pre-existing medical conditions that place the patient at greater physical risk, and for those with a history of physical or sexual abuse that places the patient at greater psychological risk.
3. Explain to the family the importance of not tampering with restraint devices or releasing the patient without informing staff.
4. 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.
5. Explain that the patient will need assistance with nutritional, range of motion, hygiene, and elimination needs.

RST-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in coping with the restraints, seclusion, or underlying problem or condition.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in coping with the restraints, seclusion, or underlying problem or condition.
3. Discuss various stress management strategies such as maintaining a healthy lifestyle.
4. Provide referrals as appropriate.

RA - Rheumatoid Arthritis

RA-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

RA-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to rheumatoid arthritis.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with rheumatoid arthritis as a life-altering illness that requires a change in lifestyle (**refer to [“RA-LA Lifestyle Adaptations](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with rheumatoid arthritis, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#)**.
6. Refer to a mental health agency or provider.

RA-C COMPLICATIONS

OUTCOME: The patient/family/caregiver will understand the 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.

RA-CM CASE MANAGEMENT

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

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](#).**

RA-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

RA-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of rheumatoid arthritis.

STANDARDS:

1. Review the disease process of rheumatoid arthritis. RA is an autoimmune disease that causes pain, swelling, stiffness, and loss of function in the joints. RA usually affects the same joints on both sides of the body. It occurs most frequently in the fingers, wrist, elbows, shoulders, jaws, hips, knees, and toes.
2. Discuss the possible cause of RA is likely a combination of genetic and environmental factors that trigger an abnormal immune response such as: genetic,

immune system defect, environmental agents (viruses and bacteria), and other factors (hormonal).

3. Explain that risk factors are something that increases the chance of getting a disease or condition. RA risk factors include: family members with RA, sex (female), ethnic background (Pima Indian), and heavy or long-term smoking.
4. Explain and discuss the signs and symptom of rheumatoid arthritis. Tell the patient/family there is no single test for RA. Diagnosis of RA is by a combination of symptoms, medical history, and physical exam of joints, skin, reflexes, and muscle strength. Symptoms may include:
 - a. Joint pain and stiffness that is symmetrical, prominent in the morning and lasts at least a half hour
 - b. Red swollen or warm joints and joint deformity
 - c. Mild fever, tiredness
 - d. Loss of appetite
 - e. Small lumps or nodules under the skin
5. Refer to the National Arthritis Foundation or community resources as appropriate.

RA-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

RA-EX EXERCISE

OUTCOME: The patient will the role of physical activity in stress reduction, sleep, bowel regulation, and improved self image.

STANDARDS:

1. Emphasize that physical activity is for maintaining muscle strength and flexibility as well as providing joint mobility. Rest helps reduce active joint inflammation and pain. Stress the importance of balancing rest and physical activity.
2. Explain that physical activity can help reduce rheumatoid arthritis symptoms, such as preventing joint stiffness, improving joint flexibility, reducing pain.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity. The three types of exercises: range of motion (stretching), strengthening (resistance/rubber bands), and endurance (brisk walking).
5. Refer to community resources as appropriate.

RA-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

RA-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding rheumatoid arthritis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding rheumatoid arthritis and dealing with issues.
2. Provide the help line phone number or Internet address (URL), such as

http://www.niams.nih.gov/Health_Info/Rheumatic_Disease/default.asp

RA-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of rheumatoid arthritis.

STANDARDS:

1. Explain the home management techniques, such as exercise and relaxation approaches, and modification of activities of daily living.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.
4. Review devices that assist in the activities of daily living and reduce stress on joints such as:
 - a. Zipper extenders
 - b. Long-handled shoehorns
 - c. Specially-designed kitchen tools

RA-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

RA-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to rheumatoid arthritis.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

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 lifestyle adaptations specific to rheumatoid arthritis.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.

4. Refer to community services, resources, or support groups, as available.

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 any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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. 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/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 understand the role of nutrition as it relates to rheumatoid arthritis.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Explain that carbohydrate intolerance may occur because of chronic inflammation and use of steroids.
6. Refer to registered dietitian for MNT or other local resources as appropriate.

RA-PM PAIN MANAGEMENT

OUTCOME: The patient/family/caregiver will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

RA-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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

RA-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. Explain this may include visits with the physical therapist as well as home exercises. **Refer to [“PT - Physical Therapy”](#).**
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.

RA-S SAFETY

OUTCOME: The patient/family/caregiver will understand the importance of injury prevention and will 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 remove 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 understand the role of stress management in rheumatoid arthritis.

STANDARDS:

1. Explain that uncontrolled stress is linked with increased exacerbations of rheumatoid arthritis.
2. Explain that effective stress management may reduce the number of relapses, as well as help improve the patient's health and well-being.
3. Discuss that increased stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use and inappropriate eating, all of which can increase the risk of morbidity and mortality from rheumatoid arthritis.
4. 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
5. Provide referrals as appropriate.

RA-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed

- c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

RA-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

RA-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 participation in the treatment plan.
2. Discuss therapies that may be utilized, such as exercise, medications, alternative therapies, joint injections, or surgery, such as joint replacement.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

RMSF - Rocky Mountain Spotted Fever

RMSF-C COMPLICATIONS

OUTCOME: The patient/family will understand the common complications of Rocky Mountain Spotted Fever (RMSF).

STANDARDS:

1. Discuss the common complications. RMSF commonly requires hospitalization. Untreated infection usually leads to death.
2. Explain that prompt treatment of any flu-like symptom(s) within days of a tick bite is essential in treating and preventing life threatening infections.
3. Discuss the possibility of long-term health problems following acute Rocky Mountain spotted fever infection (including partial paralysis of the lower extremities, gangrene, hearing loss, loss of bowel or bladder control, movement disorders, and language disorders).
4. Explain that these complications are most frequent in persons recovering from severe, life-threatening disease, often following lengthy hospitalizations.

RMSF-DP DISEASE PROCESS

OUTCOME: The patient/family will understand RMSF.

STANDARDS:

1. Explain that RMSF is a severe bacterial infection transmitted through ticks infected with RMSF.
2. Explain that the incubation period for RMSF is approximately 5-10 days. Prompt treatment of any flu-like symptoms within days of a tick bite is essential in life-saving diagnosis and treatment.
3. Discuss the early and late symptoms of RMSF.
 - a. Early symptoms include fever, nausea, vomiting, severe headache, muscle pain, lack of appetite.
 - b. Late symptoms include abdominal pain, joint pain, diarrhea.
 - c. RMSF rash may erupt following the onset of fever. In many cases, the classic RMSF rash is not present.

RMSF-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

RMSF-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding RMSF.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding RMSF and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

RMSF-L LITERATURE

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

STANDARDS:

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

RMSF-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.

RMSF-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for RMSF.

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.

RMSF-P PREVENTION

OUTCOME: The patient/family/caregiver will understand ways to reduce risk of becoming infected with RMSF.

STANDARDS:

1. Discuss ways of avoiding tick bites using personal protection:
 - a. wear light-colored clothing
 - b. tuck pants legs into socks
 - c. apply tick repellents (permethrin or DEET)
2. Discuss the importance of prompt, careful inspection, and removal of ticks. The use of mirrors may help with self inspection.

3. Discuss the importance of controlling the tick population on personal property (ex: the importance of lawn maintenance to eliminate unused furniture/mattresses, overgrown weeds, and other breeding areas).
4. Discuss the use of flea/tick collars and medicines for pets to prevent the spread of ticks inside the home.

RMSF-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

RMSF-TX TREATMENT

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

STANDARDS:

1. Discuss that prompt tick removal should be done to minimize exposure. Ticks should be removed with tweezers close to the skin.
2. Discuss the types of treatment used for RMSF, including Antibiotic therapy a potential life saving treatment.
3. Emphasize the importance of active participation by the patient/family in the treatment plan.
4. Explain that various treatments have inherent risks, side effects, and benefits.

S**SARC - Sarcoidosis****SARC-AP ANATOMY AND PHYSIOLOGY**

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

STANDARDS:

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

SARC-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components as it relates to sarcoidosis.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with sarcoidosis as a life-altering illness that requires a change in lifestyle (**refer to ["SARC-LA Lifestyle Adaptations"](#)**).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with sarcoidosis, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to ["AOD - Alcohol and Other Drugs"](#)**.
6. Refer to a mental health agency or provider.

SARC-C COMPLICATIONS

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

STANDARDS:

1. Explain that untreated pulmonary sarcoidosis can lead to irreversible damage to the tissue between the air sacs in the lungs making it difficult to breathe. Lung

problems may include persistent dry cough, shortness of breath, wheezing, or chest pain.

2. Explain that inflammation can affect almost any part of the eye and can eventually cause blindness. Sarcoidosis can also cause cataracts and glaucoma, although this is rare. Eye symptoms may include blurred vision, eye pain, severe redness, and sensitivity to light.
3. Explain that some individuals develop skin problems. Skin problems may include rash, disfiguring skin lesions, color change and growths just under the skin, particularly around scars or tattoos.
4. Explain that sarcoidosis can affect how the body handles calcium and this can result in kidney stones and kidney failure.
5. Explain that granulomas within the heart can interfere with electrical signals that drive the heartbeat and can cause arrhythmias and even death. This occurs very rarely.
6. Explain that a small percentage of people with sarcoidosis develop problems related to the central nervous system when granulomas form in the brain and spinal cord. Inflammation of the facial nerves can cause facial paralysis.

SARC-CM CASE MANAGEMENT

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

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”](#).**

SARC-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.

2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

SARC-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the sarcoidosis.

STANDARDS:

1. Explain that sarcoidosis is an inflammatory disease that affects multiple organs in the body, but mostly in the lungs, lymph glands, eyes, and skin. Sarcoidosis is not cancer, nor is it contagious.
2. Explain that abnormal masses or nodules (called granulomas) consisting of inflamed tissues form in certain organs. These granulomas may alter the structure and functions of the affected organs.
3. Explain that the exact cause of sarcoidosis is unknown. Some people appear to have a genetic predisposition for developing the disease, which may be triggered by exposure to certain bacteria, viruses, dust, or chemicals. The disease is associated with an abnormal immune response but what triggers this response is unknown. The course of sarcoidosis is variable from person to person. Often, it goes away on its own, but in some people signs and symptoms of sarcoidosis may last a lifetime.
4. Explain that sarcoidosis usually occurs between the ages of 20 and 40. Women are slightly more likely to develop the disease than are men. Symptoms may worsen after pregnancy.
5. Explain that if someone in the family has sarcoidosis, the patient is more likely to develop the disease.

SARC-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction

- f. infection control principles, including proper disposal of associated medical supplies
- g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

SARC-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

SARC-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

SARC-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding sarcoidosis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding sarcoidosis and dealing with issues.
2. Provide the help line phone number or Internet address (URL), such as

National Heart, Lung and Blood Institute:

<http://www.nhlbi.nih.gov>

National Sarcoidosis Resource Center:

<http://www.ncrc-global.net>

American Lung Association:

<http://www.lungusa.org>

SARC-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of sarcoidosis.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

SARC-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary

4. Review the community resources available for help in achieving behavior changes.

SARC-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to sarcoidosis.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

SARC-L LITERATURE

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

STANDARDS:

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

SARC-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for sarcoidosis.

STANDARDS:

1. Discuss lifestyle adaptations specific to sarcoidosis.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.

3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

SARC-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

SARC-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for sarcoidosis.

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.

SARC-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to sarcoidosis.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Explain the importance of maintaining healthy weight, especially if being treated with steroids.
6. Refer to registered dietitian for MNT or other local resources as appropriate.

SARC-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.

4. Discuss the importance of advanced family planning (reproductive planning).
Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

SARC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

SARC-PRO PROCEDURE

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 of the proposed procedure (such as bronchoscopy, biopsy) 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 for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site

- d. time out for patient identification and procedure review
- e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

SARC-SHS SECOND-HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Explain that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, carcinogens.
3. Explain the increased risk of illness when exposed to tobacco smoke, e.g., increased colds, asthma, ear infections, pneumonia, SIDS, and lung cancer.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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.

SARC-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in sarcoidosis.
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.

SARC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

SARC-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

SARC-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

SARC-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

SCBE - Scabies

SCBE-C **COMPLICATIONS**

OUTCOME: The patient/family will understand the complications relating to scabies.

STANDARDS:

1. Explain that intense itching from scabies may interfere with sleep.
2. Explain that itching may result in secondary bacterial infection.

SCBE-DP **DISEASE PROCESS**

OUTCOME: The patient/family will understand scabies.

STANDARDS:

1. Explain that scabies is caused by mites that burrow in the skin. The early and common symptoms of scabies include: itching (especially at night), little red bumps, hives, tiny bites, or pimples. In more advanced cases, the skin may be crusty or scaly with tracks.
2. Discuss the transmission of scabies. It is almost always caught from a close contact. It can be transmitted through direct skin contact, shared items, and bedding. Everyone is susceptible, but it is more often seen in crowded living conditions with poor hygiene.
3. Explain that mites prefer warm areas e.g., skin folds, where clothing is tight, between the fingers, under the finger nails, and on the buttocks. Mites also tend to hide around bracelets, watchbands, and rings. In children, the infestation may involve the entire body including the palms, soles, and scalp.

SCBE-FU **FOLLOW-UP**

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

SCBE-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of scabies.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

SCBE-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to the prevention and treatment of scabies.

STANDARDS:

1. Discuss the importance of hand-washing in infection control, especially in relationship to food preparation/consumption, child care, and toilet use.
2. Explain the importance of laundering clothing and linens in infected households:
 - a. Wash all bed linens and clothing in very hot water (130° Fahrenheit, or 54.4° Celsius) then put them in the hot cycle of the dryer for at least 30 minutes.
 - b. Dry-clean bed linens, clothing, stuffed animals, and plush toys that can't be washed, or put them in airtight bags for two weeks.
3. Instruct to vacuum carpets and any upholstered furniture (in the home or car). Afterwards, dispose of the vacuum contents.
4. Explain that everyone is susceptible to scabies, although, it is more often seen in crowded living conditions with poor hygiene.
5. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.

SCBE-L LITERATURE

OUTCOME: The patient/family will receive literature about the prevention and treatment of scabies.

STANDARDS:

1. Provide the patient/family with literature on scabies.

2. Discuss the content of the literature.

SCBE-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

SCBE-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of acquiring scabies.

STANDARDS:

1. Explain that getting rid of the mites is critical in the treatment and prevention of scabies. Everyone in the family or group, whether itching or not, should be treated at the same time to stop the spread of scabies. This includes close friends, day care or school classmates, or nursing home residents. Pets do not need treatment.
2. Explain that bedding and clothing must be washed or dry cleaned.
3. Explain that frequent hand washing may help reduce exposure

SCBE-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 participation in the treatment plan.
2. Discuss therapies that may be utilized including creams, lotions, and anti-histamines.

3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.

SZ - Seizure Disorder

SZ-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of the brain as it relates to seizure disorders.
2. Discuss the changes to anatomy and physiology as a result of a seizure disorder.
3. Discuss the impact of these changes on the patient's health or well-being.

SZ-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to seizure disorders.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with seizure disorder as a life-altering illness that requires a change in lifestyle (refer to [“SZ-LA Lifestyle Adaptations](#)).
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with seizure disorder, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. Refer to [“AOD - Alcohol and Other Drugs](#).
6. Refer to a mental health agency or provider.

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 that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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 many 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.

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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding seizure disorders.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding seizure disorders and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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 because these may precipitate seizures, and encourage the patient to learn to control stress, e.g., relaxation techniques. **Refer to [“CPM-SM Stress Management.”](#)**
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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

SZ-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable
 - d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
5. Refer for medical and psychosocial support services for any risk factor identified.

SZ-S SAFETY

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 because 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 the patient to time and place and informing the patient about the seizure.
 - h. Patients who have frequent violent seizures may require a helmet for head protection.
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, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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.

SEP - Separation Anxiety Disorder

SEP-C **COMPLICATIONS**

OUTCOME: The patient/family will understand the complications associated with Separation Anxiety Disorder.

STANDARDS:

1. Discuss that Separation Anxiety Disorder often leads to school refusal, which may lead to academic difficulties and social avoidance.
2. Discuss that the family conflict and dysfunction may arise from parental frustration with the child's excessive demands.
3. Explain that Separation Anxiety Disorder often precedes Panic Disorder with Agoraphobia (refer to [“PANIC - Panic Disorder”](#)), and that anxiety and depressed mood is frequently present and may become more pronounced over time.

SEP-CM **CASE MANAGEMENT**

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in the treatment of Separation Anxiety Disorder.

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”](#).

SEP-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

SEP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of Separation Anxiety Disorder.

STANDARDS:

1. Explain that Separation Anxiety Disorder is a developmentally inappropriate anxiety concerning separation from home or from major attachment figures.
2. Discuss the symptoms of Separation Anxiety Disorder, which usually includes several or most of the following:
 - a. Excessive distress when separation from home or major attachment figures occurs or is anticipated
 - b. Excessive worry about losing major attachment figures
 - c. Excessive worry that an adverse event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
 - d. Reluctance or refusal to go to school or elsewhere because of fear of separation
 - e. Reluctance or refusal to go to sleep without being near a major attachment figure, or to sleep away from home
 - f. Repeated nightmares involving the theme of separation
 - g. Repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting)
3. Explain that symptoms of Separation Anxiety Disorder must have lasted at least a period of four weeks, and may persist for years with periods of exacerbation and remission.
4. Discuss other associated features of Separation Anxiety Disorder:
 - a. Children with this Disorder are often described as demanding, intrusive, and in need of constant attention. Conversely, sometimes children with this disorder are described as unusually conscientious, compliant, and eager to please
 - b. Depending on their age, individuals may have fears of people, places, and situations that may present a danger to the integrity of the family
 - c. Concerns about death and dying are common
 - d. When alone, especially at night or in the dark, young children may report unusual perceptual disturbances, such as seeing people peering into their room, feeling eyes staring at them, or scary creatures reaching for them
5. Discuss the differential diagnosis.

SEP-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in coping with Separation Anxiety Disorder.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

SEP-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

SEP-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding separation anxiety disorder.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding separation anxiety disorder.
2. Provide the help line phone number or Internet address (URL).

SEP-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

SEP-L LITERATURE

OUTCOME: The patient/family will receive literature about Separation Anxiety Disorder.

STANDARDS:

1. Provide the patient/family with literature on Separation Anxiety Disorder.
2. Discuss the content of the literature.

SEP-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

SEP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for Separation Anxiety 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.

SEP-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to Separation Anxiety Disorder.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

SEP-PA PARENTING

OUTCOME: The patient/family will understand parenting skills necessary for helping the child to cope with Separation Anxiety Disorder.

STANDARDS:

1. Emphasize the importance for parents to learn strategies for reducing or eliminating anxiety around separation, which includes:
 - a. Practicing separation for brief periods and short distances, increasing them as the child can tolerate it
 - b. Scheduling separations after naps or feedings because babies are more susceptible to separation anxiety when they're tired or hungry
 - c. Letting the child become comfortable with new surroundings with a parent present and allowing the child to bring a favorite object or toy
 - d. Not sneaking away without saying goodbye
2. Refer the family to mental health services/ family counseling if the family is becoming overwhelmed.

SEP-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of Separation Anxiety Disorder.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

SEP-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in reducing anxiety and family conflict.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in coping with Separation Anxiety Disorder.
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.

SEP-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

SEP-TX TREATMENT

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

STANDARDS:

1. Explain the treatment for Separation Anxiety Disorder is usually very effective, and may involve a combination of psychotherapy and medication. Explain that parental participation in the treatment is critical to a good outcome (refer to [“SEP-PA Parenting”](#)).

2. Explain that therapists have different styles and orientations for treating Separation Anxiety Disorder, and that some styles may suit the patient and family better than others. Strategies include:
 - a. Cognitive Behavioral Therapy
 - b. Family therapy
 - c. Consultation with the child's school
3. Explain that anti-depressant or anti-anxiety medication may also benefit the child in combination with the psychotherapy to help the child feel calmer.
4. Explain any life stressors that often precede Separation Anxiety Disorder, (e.g., the death of a relative or pet, a change of schools, a move to new neighborhood, or immigration), and treat accordingly.
5. Explain that the treatment plan will be made by the parents and the treatment team after reviewing available options. Explain that treatment for Separation anxiety may vary according to the patient's life circumstances, severity of the condition, the child's tolerance for the therapy or medication, the family's participation in the intervention, and available resources.

SARS - Severe Acute Respiratory Syndrome

SARS-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

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 virus. This virus is similar to the coronavirus, which is a frequent cause of the common cold.
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:
 - a. Starts 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.

- b. After three to seven days, respiratory symptoms such as a nonproductive cough and dyspnea may begin.
 - c. 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HY HYGIENE

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

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.

4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.
6. 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 the 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 SARS 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.
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 SARS. 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/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 nutrition, as it related to SARS.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the need for adequate hydration.
4. Refer to registered dietitian for MNT or other local resources as appropriate.

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 virus that causes SARS such as avoidance of people exposed to SARS or who have SARS and following CDC travel advisories. It is not known whether wearing a surgical mask prevents the spread or contracting the virus.
2. Discuss the importance of good hygiene and avoidance of high-risk behavior.
3. Explain that SARS 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-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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

SARS-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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.

SEX - Sexual Disorders

SEX-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of the sexual organs and normal sexual response cycle.
2. Discuss the impact of changes to the normal sexual response cycle and their effect on the patient's health or well-being.

SEX-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components as it relates to sexual disorders.

STANDARDS:

1. Discuss the potential stress other emotional reactions that are common in being diagnosed with a sexual disorder, and the danger of further complications or mental health diagnoses related to it.
2. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
3. Discuss the problems and consequences of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
4. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to ["AOD - Alcohol and Other Drugs"](#).**
5. Refer to a mental health agency or provider.

SEX-C COMPLICATIONS

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

STANDARDS:

1. Explain that individuals with a sexual disorder may suffer related anxiety and sexual frustration, which in turn may lead to insomnia, and this insomnia, for example, may be the presenting complaint to the general practitioner.
2. Explain that sexual disorders interfere with family and social functioning.

SEX-CM CASE MANAGEMENT

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

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”](#).**

SEX-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 health and wellness.

STANDARDS:

1. Discuss the role of culture in defining what is considered distressing or pathological regarding sexual dysfunction.
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
3. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

SEX-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the signs and symptoms of sexual disorders.

STANDARDS:

1. Explain that a diagnosis of a sexual disorder requires marked distress or interpersonal difficulty, and is not better accounted for by another mental health diagnosis.
2. Explain the essential features and symptoms of sexual disorders:
 - a. **Sexual dysfunctions** are characterized by disturbance in sexual desire and in the physiological changes that characterize the sexual response cycle (i.e., desire, excitement, orgasm, and resolution), which include:

- i. **Hypoactive Sexual Desire Disorder** is the persistently deficient (or absent) sexual fantasies and desire for sexual activity.
 - ii. **Sexual Aversion Disorder** is persistent extreme aversion to, and avoidance of all (or almost all) genital sexual contact with a sexual partner.
 - iii. **Female Sexual Arousal Disorder** is the persistent inability to attain, or to maintain an adequate lubrication-swelling response of sexual excitement until completion of the sexual activity.
 - iv. **Male Erectile Disorder** is the persistent inability to attain or maintain an adequate erection until completion of sexual activity.
 - v. **Female Orgasmic Disorder** is the persistent delay in, or absence of, orgasm following a normal sexual excitement phase, which is judged to be considerably less than would be reasonable considering the variability among women.
 - vi. **Male Orgasmic Disorder** is the persistent delay in, or absence of orgasm following normal sexual excitement phase during sexual activity.
 - vii. **Premature Ejaculation** is the persistent ejaculation with minimal stimulation before, on, or shortly after penetration and before the person wishes it, ruling out issues related to age, novelty of the sexual partner or situation, and recent frequency of sexual activity.
 - viii. **Dyspareunia** is the recurrent or persistent genital pain associated with sexual intercourse in either a male or female.
 - ix. **Vaginismus** is the recurrent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse.
 - x. **Substance-Induced Sexual Dysfunction** is diagnosed when the dysfunction is fully explained by substance use (including medications) as evidenced from history, physical exam, or laboratory findings, which developed within one month of intoxication.
- b. **Paraphilias** are characterized by recurrent, intense sexual urges, fantasies, or behaviors that involve unusual objects, activities, or situations for at least six months, which include:
- i. **Exhibitionism** is the recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the exposure of one's genitals to an unsuspecting stranger
 - ii. **Fetishism** is the recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the use of nonliving objects (e.g., female undergarments).
 - iii. **Frotteurism** is the recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a non-consenting person.

- iv. **Pedophilia** involves a person age 16 years or older who experiences recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 or younger), who is at least 5 years younger than the perpetrator.
 - v. **Sexual Masochism** is recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer.
 - vi. **Sexual Sadism** is recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving real acts in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person.
 - vii. **Transvestic Fetishism**, in heterosexual male, is recurrent intense sexually arousing fantasies, sexual urges, or behaviors involving cross dressing, sometimes with discomfort with gender role identity.
 - viii. **Voyeurism** is recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity.
 - ix. **Paraphilias Not Otherwise Specified** include such sexually arousing activities not already categorized, such as obscene phone calls, necrophilia (corpses), zoophilia (animals), or urophilia (urine).
3. Explain that poor communication among partners is almost always associated with sexual dysfunction.
 4. Explain that the “unusual” activities noted in paraphilias only become pathologic if these activities are obligatory for sexual functioning, involve inappropriate partners, or involve problems with consenting partners.
 5. Explain that the pattern of erotic arousal may be fairly well developed before puberty, and may involve:
 - a. anxiety or early emotional trauma that interferes with normal psychosexual development
 - b. the standard pattern of arousal is replaced by another pattern, sometimes through highly charged sexual experiences that reinforce the person's experience of sexual pleasure
 - c. the pattern of sexual arousal often acquires symbolic and conditioning elements (e.g., a fetish was accidentally associated with sexual curiosity, desire, and excitement)
 - d. some abnormal brain function
 6. Explore and rule out medical causes to the specific sexual disorders, such as ruling out genital infections or irritation as the cause of dyspareunia.

SEX-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in improving sexual health.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

SEX-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

SEX-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:

- a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

SEX-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.

SEX-L LITERATURE

OUTCOME: The patient/family will receive literature about sexual disorders.

STANDARDS:

1. Provide the patient/family with literature on specific sexual disorders.
2. Discuss the content of the literature.

SEX-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for optimizing interpersonal and sexual functioning.

STANDARDS:

1. Discuss adaptations necessary for optimizing sexual health and healthy relationships, including:
 - a. communicating concerns and desires with the partner
 - b. understanding anatomy and the body's normal response to sexual activity
 - c. coping with and expressing negative emotions appropriately
2. Discuss ways to optimize quality of life, including regular exercise and well balanced meals.
3. Refer to community services, resources, or support groups, as available.

SEX-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

SEX-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient; and it may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain.
4. Explain non-pharmacologic measures that may be helpful with pain control.

SEX-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of sexual disorders.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

SEX-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to sexual disorders.

STANDARDS:

1. Discuss safety as it pertains to the particular sexual disorder.
2. Discuss the safety of children and non-consenting persons.
3. Review the local resources and phone numbers, including the police that may be utilized during a crisis, and may assist in transportation and safety compliance.

SEX-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in reducing sexual dysfunction.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect on relationships and sexual function.
2. Explain the role of effective stress management in coping with marital or interpersonal functioning, and the anxiety related to sexual dysfunctions.
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.

SEX-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options for sexual disorders.

STANDARDS:

1. Explain that a combination of psychotherapy and medication interventions (for associated conditions) usually has better results than therapy or medication alone. The patient has a right to choose either option or both, and that the patient's active participation in the treatment decisions is critical to a good outcome.
2. Explain that many sexual dysfunctions resolve when relationship problems are corrected, which are often facilitated within marital counseling.
3. Discuss the tailored treatment approach for the patient based on the patient's specific symptoms, issues, and strengths, which must address both the physical and psychological aspects of the problem. Specific interventions include:
 - a. Individual psychotherapy and couples counseling, which may involve:
 - i. improving communication among partners
 - ii. conflict resolution skills
 - iii. providing education on sexual function and anatomy
 - iv. enhancing stimulation and eliminating or reducing routine sexual practices
 - v. providing distraction techniques, such as relaxation exercises
 - vi. encourage non-coital behaviors, such as sensate focus exercises or sensual massage
 - vii. use of products to minimize pain or increase sensitivity, such as lubricating gels and creams, or topical estrogen
 - b. Support or Educational Groups
 - c. Medications may be prescribed to manage associated symptoms, such as anxiety or depression (**refer to [“SEX-M Medications”](#)**).
4. Explain that the treatment plan will be made by the patient and treatment team after reviewing available options. Explain that treatment for sexual disorders may vary according to the patient's life circumstances, severity of the condition, the patient's participation in the choices, and available resources.

STI - Sexually Transmitted Infections

STI-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of the reproduction system as it pertains to sexually transmitted infections.
2. Discuss the changes to anatomy and physiology as a result of sexually transmitted infections.
3. Discuss the impact of these changes on the patient's health or well-being.

STI-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to sexually transmitted infections.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with sexually transmitted infections as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with sexually transmitted infections, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs.](#)**
6. Refer to a mental health agency or provider.

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. Other complications may include:
 - a. cancer of reproductive system
 - b. chronic pain
 - c. neurological, cardiovascular, and other systemic conditions
2. Explain that some STIs if left untreated can progress to disability, disfigurement, and/or death. Discuss specific STI complications as appropriate.
3. Discuss that having one sexually transmitted infection greatly increases a person's risk of having a second sexually transmitted infection.
4. Discuss that some sexually transmitted infections can be life-long or fatal.
5. Explain STIs can be passed from a pregnant woman to her unborn fetus, or to infants during vaginal delivery or through breast milk (HIV). Complications for a pregnant woman and baby may include:
 - a. pregnant woman: spontaneous abortion, early onset of labor, premature rupture of membranes, and uterine infection after delivery
 - b. babies: stillbirth, low birth weight, eye infection, neurologic damage, neonatal sepsis, blindness and deafness

STI-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

STI-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the specific sexually transmitted infections.

STANDARDS:

1. Explain that STIs can be caused by bacteria (e.g. chlamydia, gonorrhea, syphilis), parasites (trichomoniasis), or viruses (e.g., HPV, genital herpes, HIV); bacterial and infections can be cured, but viral infections can be managed but not always cured. Discuss the specific STI as appropriate.
2. Explain that most STIs can occur without noticeable symptoms in both men and women, thus it is important to get tested prior to and/or after engaging in unprotected sexual encounters; common STI symptoms include:
 - a. sores, blisters or bumps on the genitals or in the oral or rectal area
 - b. pain or swelling of glands in the groin area
 - c. vaginal or penile discharge
 - d. painful or burning urination
 - e. unusual vaginal bleeding
3. Discuss the modes of transmission of STIs which include:
 - a. sexual contact (vaginal, anal, or oral sex)
 - b. mixture of infectious body fluids (blood, semen, vaginal secretions)
 - c. skin to skin contact
 - d. from a pregnant woman to the unborn fetus, or to infants during vaginal delivery or through breast milk (HIV)
 - e. sharing needles and/or syringes including those used for drugs, body piercing or tattoos or needle stick injuries

STI-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care including:
 - a. annual testing for sexually active women under age 26
 - b. repeat testing for women diagnosed with Chlamydia (3 months from initial diagnosis date) due to the risk for re-infection
 - c. routine STI testing for persons that engage in unprotected sexual activity with multiple or non-monogamous partners or who participate in risky sex practices that can break the skin
2. Discuss signs/symptoms that should prompt immediate follow-up.
3. Re-emphasize the importance of getting partners treated to minimize risk of re-infection and spread of infection.

4. Discuss the procedure and process for obtaining follow-up appointments.
5. Discuss the availability of community resources and support services and refer as appropriate.
6. Discuss public health reporting requirements.

STI-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding sexually transmitted infections.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding sexually transmitted infections and dealing with issues.
2. Provide the help line phone number or Internet address (URL, such as:
American Social Health Association: provides information, materials, and referrals concerning sexually transmitted infections. Specialists will answer questions via phone or email on transmission, risk reduction, prevention, testing, and treatment. Voice: 1-800-227-8922

CDC National Prevention Information Network: provides information on resources, education materials, sexually transmitted diseases (including AIDS/HIV), tuberculosis, and communities at risk via touch tone phone or online. Many different service and publications offered. Voice: 1-800-458-5231, Email: info@cdcnpin.org, Website: <http://www.cdcnpin.org>

CDC National STD/AIDS Hotline: provides education and research about AIDS, HIV, and sexually transmitted diseases. Voice: 1-800-232-4636, Email: cdcinfo@cdc.gov, Website: <http://www.cdcn.gov>

STI-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high-risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy

- b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

STI-P PREVENTION

OUTCOME: The patient/family/partner will plan behavior patterns that will prevent sexually transmitted infections.

STANDARDS:

1. List the behaviors that eliminate or decrease risk of contracting a sexually transmitted infection:
 - a. abstinence (the most effective way to avoid STIs)
 - b. monogamous relationship with an uninfected partner
 - c. use condoms consistently and correctly; use a new latex or polyurethane condom for each sex act
 - d. avoid abusing alcohol or using recreational drugs or injecting drugs
 - e. avoid risky sex practices that can break skin
 - f. get immunized early before sexual exposure (vaccinations are available that can prevent hepatitis B and most common types of HPV)
2. Discuss the proper condom use, storage, and disposal:
 - a. latex condoms are made of rubber; use only water-based lubricants (e.g., K-Y, Astroglide, Foreplay)
 - b. polyurethane condoms are made of plastic and are recommended when sensitivity to latex is an issue; these condoms can be used with water-based or oil based lubricants
 - c. store condom in cool, dry place out of direct sunlight (i.e., condom case); check package for damage or expiration prior to use
 - d. when used, remove the condom carefully, wrap it in tissue, and place it in a garbage can -- not in a toilet
 - e. never reuse condoms

STI-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable

- d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
 3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
 4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
 5. Refer for medical and psychosocial support services for any risk factor identified.

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 the role of effective stress management in reducing 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, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results
 - e. public health reporting requirements

STI-TX TREATMENT

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

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of early detection, early treatment, and active participation by the patient/partner/family in the development of and participation with treatment plan.
2. Stress the importance of treatment of the sexual contacts, and the need to avoid sexual activity while under treatment for an STI to minimize the risk of re-infection and spread of the infection.
3. Discuss the therapies that may be utilized.
4. Explain the various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
5. Emphasize the importance of reporting participation in unsafe sexual behaviors or risky sex practices to the healthcare provider in order to receive appropriate testing and treatment based on risk behavior and exposure.
6. Discuss public health reporting requirements.

SHI - Shingles

SHI-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

SHI-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to shingles.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with shingles as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with shingles, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).**
6. Refer to a mental health agency or provider.

SHI-C COMPLICATIONS

OUTCOME: The patient or family will understand common complications of shingles.

STANDARDS:

1. Explain that irritation of nerves may cause post-herpetic neuralgia (or PHN). This causes the skin to become unusually sensitive to clothing, to a light touch, even to temperature. Pain may continue for long period of time after the rash has healed.
2. Explain that if the virus invades an ophthalmic nerve it can cause painful eye inflammations that can impair the vision.

3. Explain that if shingles appears on the face and affects the auditory nerves, it can lead to complications in hearing.
4. Explain that infections of facial nerves can lead to temporary paralysis.
5. 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 will 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-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.

4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

SHI-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding shingles.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding shingles and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

SHI-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:

- a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

SHI-MNT MEDICAL NUTRITION THERAPY

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

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 role of nutrition in shingles.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.

SHI-P PREVENTION

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

STANDARDS:

1. Explain that a single dose of shingles vaccine can reduce the risk of shingles by half, and is recommended for some adults 60 years of age or older.
2. Discuss the importance of avoiding exposure to chicken pox.

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, weight loss, and can 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, 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-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

SHI-TX TREATMENT

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

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 sick time – 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.

SINUS - Sinusitis

SINUS-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

SINUS-C COMPLICATIONS

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

STANDARDS:

1. Explain that complications resulting from sinusitis are relatively rare, but when they occur they may be life-threatening and require extensive medical or surgical treatment.
2. Explain that complications usually involve the spread of infection beyond the sinuses to the facial bones (osteomyelitis), brain lining (meningitis), or facial tissues.
3. Explain that untreated sinusitis may lead to nasal polyps and may also increase the symptoms of asthma and chronic lung diseases.

SINUS-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

SINUS-DP DISEASE PROCESS

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

STANDARDS:

1. Explain that sinusitis involves the inflammation and swelling of the mucous membranes lining the upper airway resulting in blockage of drainage which causes pressure and pain.
2. Explain that related symptoms are yellow or greenish discharge from the nose, head ache, bad breath, stuffy nose, cough, fever, tooth pain, and reduced sense of taste or smell.
3. Explain that sinusitis usually results from a viral infection, but can also be related to nasal allergies, nasal polyps, foreign objects, structural problems (deviated septum), and other conditions that can block the nasal passages and predispose to sinusitis.
4. Explain that acute sinusitis usually improves without treatment, but it can predispose to a bacterial infection that can become chronic and cause permanent changes in the mucous membranes that line the sinuses.

SINUS-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.
5. Discuss the availability of community resources and support services and refer as appropriate.

SINUS-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding sinusitis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding sinusitis and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

SINUS-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of sinusitis.

STANDARDS:

1. Explain, as appropriate, the following therapies:
 - a. Drinking plenty of fluids to help keep mucus thin.
 - b. Applying moist heat to the face for 5 to 10 minutes, several times daily.
 - c. Breathing warm, moist air from a steamy shower, hot bath, or sink filled with hot water and avoiding cool, dry air. A home humidifier may also be considered.
 - d. Using saltwater nasal washes to help keep nasal passages open and cleaned of mucus and bacteria.
 - e. Using nonprescription medications such as pain relievers and decongestants to relieve symptoms.
 - f. Blowing the nose gently, when necessary, to keep from forcing thick mucus back into the sinuses.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

SINUS-L LITERATURE

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

STANDARDS:

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

SINUS-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

SINUS-P PREVENTION

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

STANDARDS:

1. Explain that sinusitis may be prevented by avoiding precipitating factors. Discuss the following as appropriate:
 - a. Promptly treating nasal congestions caused by colds or allergies to prevent secondary bacterial infections of the sinuses.
 - b. Avoiding contact with people who have colds and other upper respiratory infections.
 - c. Decreasing the risk of infection by frequently washing the hands.
 - d. Avoiding cigarette, cigar, and pipe smoke.
 - e. Avoiding allergenic triggers or considering immunotherapy (allergy shots).
 - f. Avoiding dry air in the home by using a humidifier.
 - g. Avoiding swimming in contaminated water
2. Discuss that daily sinus irrigation may prevent sinusitis.

SINUS-PRO PROCEDURES

OUTCOME: The patient/family will understand 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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:

- a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

SINUS-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 x-rays, CT/MRI scans, or other tests may be necessary if the diagnosis is not clear, antibiotic treatment has failed, sinusitis recurs, complications are suspected, or surgery is being considered.
2. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
3. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

SINUS-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 the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation with treatment plan.
2. Discuss therapies that may be utilized.

3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

SWI - Skin and Wound Infections

SWI-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

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 fasciotomy and skin grafting, multi-organ failure, death).
3. Inform patient/family that scarring and/or tissue discoloration may develop after healing of the wound.
4. Emphasis the importance of early treatment to prevent complications.

SWI-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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. Review, as appropriate, peripheral vascular disease and/or ischemic ulcers as appropriate. **Refer to [“PVD - Peripheral Vascular Disease”](#).**
2. Explain how breaks in the skin can allow bacteria to enter the body. Even minor wounds should be kept clean and treated early to prevent serious skin or wound infections. Discuss the need to identify and treat skin fungal infections (e.g. athlete’s foot).
3. Explain, as appropriate, that elevated blood sugar or the use of immunosuppressive/corticosteroid medication may increase the risk of serious skin and wound infections and impedes healing.
4. Explain that skin infections may start as small pustules or boils, which are often red, swollen, painful, or have pus associated with them. They commonly occur at sites of visible skin trauma, such as cuts or abrasions, or can occur at sites commonly covered by hair on the body, like the back of the neck, groin, buttock, or armpit.
5. Discuss, if appropriate, that lesions that mimic spider bites may in fact be community-acquired MRSA and may require special attention.

SWI-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indications for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
2. Demonstrate and participate in a return demonstration of the safe and proper use, care, and cleaning of the equipment, as appropriate.

3. 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.
4. Emphasize the importance of not tampering with any medical device.

SWI-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in skin and wound infections.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Discuss 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-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of skin and wound infections.

STANDARDS:

1. Explain the home management techniques.

2. Discuss the implementation of hygiene and infection control measures in the home, including sanitation (specific cleansers), personal protective equipment, and isolation.
3. Refer to community resources, hospice, or support groups, as appropriate.

SWI-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

SWI-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to skin and wound infections.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.

3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

SWI-ISO ISOLATION

OUTCOME: The patient/family will understand the reasons and procedures for isolation of the patient in preventing and controlling the spread of skin infections.

STANDARDS:

1. Explain that isolation of the patient prevents the spread of antibiotic associated diarrhea to healthcare providers, other patients, and family members.
2. Describe the type of isolation being implemented and associated precautions and protective equipment to be used. Refer to [“MDRO - Multidrug-resistant Organism”](#).

SWI-L LITERATURE

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

STANDARDS:

1. Provide the 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 full participation with the medication plan and that this is the patient’s responsibility. Discuss any barriers to full participation.

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.

SWI-MNT MEDICAL NUTRITION THERAPY

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

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. Explain that protein foods, such as meat, fish, nuts, dairy, and soy are important in repairing tissues.
3. Explain that zinc, vitamins A and C, and thiamine are necessary for the healing process.
4. Explain that if oral intake is poor, small, frequent meals and a multi-vitamin help meet nutritional needs.
5. Refer to a registered dietitian 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”](#).**
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”](#).**
4. Discuss that if participating in contact sports where there is skin to skin contact, it is important to shower immediately after the activity and to not share personal items such as towels or razors. Stress the importance of keeping surfaces that come into frequent contact with bare skin (e.g. exercise equipment), cleaned frequently. Explain the importance of keeping skin abrasions or cuts covered with clean, dry bandages.
5. Discuss the need for tobacco cessation. **Refer to [“TO - Tobacco Use”](#).**

SWI-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”](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

SWI-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

SWI-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

SWI-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

SWI-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

SLEEP - Sleep Disorders

SLEEP-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components as it relates to sleep disorder.

STANDARDS:

1. Discuss the potential stress and emotional reactions that are common in being diagnosed with a sleep disorder, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
2. Discuss the primary diagnosis related to secondary sleep disorder.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#).**
5. Refer to a mental health agency or provider.

SLEEP-C COMPLICATIONS

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

STANDARDS:

1. Discuss that chronic insomnia may lead to decreased feelings of well-being during the day, including deterioration of mood and motivation, a decrease in attention, energy, and concentration, and increase in fatigue and malaise.
2. Explain that sleep disturbances often progress, and that interpersonal, social, and occupational problems may develop as a result of over-concern with sleep, increased daytime irritability, and poor concentration.
3. Explain that insomnia often persists long after the original causative factors resolve due to the development of heightened arousal and negative conditioning, and may become a primary sleep disorder.
4. Explain that daytime sleepiness and some sleep disorders can be embarrassing and even dangerous, if, for instance, the individual is driving or operating machinery.
5. Explain that chronic insomnia and some sleep disorders may lead to memory disturbance, personality changes, mood disorders, particularly Depression (**refer to [“DEP - Depressive Disorders”](#)**), and Anxiety Disorders.
6. Explain that children with sleep disorders may have developmental delays (**refer to [“PDD - Pervasive Developmental Disorders”](#)**) or learning disabilities (**refer to [“LD - Learning Disorders/Disabilities”](#)**).

SLEEP-CM CASE MANAGEMENT

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

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”](#).**

SLEEP-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

SLEEP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of sleep disorders.

STANDARDS:

1. Discuss the etiology and essential features of the sleep disorder:
 - a. **Primary sleep disorders** are those whose etiologies do not include another mental disorder, substance abuse disorders (**refer to [“AOD - Alcohol and Other Drugs”](#)**), or a general medical condition. They are subdivided into dyssomnias (characterized by abnormalities in amount, quality or timing of sleep) and **parasomnias** (categorized by abnormal behavioral or physiological events that may lead to intermittent awakenings).

- b. **Sleep Disorder Related to Another Mental Disorder** results from a diagnosable mental disorder but is sufficiently severe enough to warrant independent clinical attention.
 - c. **Sleep Disorder Due to a General Medical Condition** results from the direct physiological effects of a general medical condition, e.g., obstructive sleep apnea (refer to [“OSA - Obstructive Sleep Apnea”](#)), heart failure, BPH.
 - d. **Substance-Induced Sleep Disorder** results from the concurrent use, or recent discontinuation of use, of a substance, including medications.
2. Explain the symptoms of the specific sleeping disorder under consideration:
- a. **Dyssomnias** involve abnormalities of the mechanisms generating sleep-wake states, and include:
 - i. **Primary Insomnia** is difficulty initiating or maintaining sleep or non-restorative sleep for at least one month.
 - ii. **Primary hypersomnia** is excessive sleepiness for at least one month as evidenced by prolonged sleep episodes or daytime sleep that occur almost daily for at least one month.
 - iii. **Narcolepsy** is characterized by repeated irresistible attacks of refreshing sleep, cataplexy, and intrusions of REM sleep in the transition period between sleep and wakefulness.
 - iv. **Breathing-Related Sleep Disorder** is sleep disruption leading to excessive sleepiness or insomnia that is judged to be due to abnormalities of ventilation during sleep (e.g., obstructive sleep apnea).
 - v. **Circadian Rhythm Sleep Disorder** is a persistent pattern of sleep disruption that is due to mismatch between the person’s sleep-wake schedule required by a person’s environment and the person’s circadian sleep-wake pattern.
 - b. **Parasomnias** represent the activation of physiological systems at inappropriate times during the sleep-wake cycle, and include:
 - i. **Nightmare Disorder** is the repeated awakenings from the major sleep period or naps with detailed recall of extended and extremely frightening dreams, usually involving threats to security, survival, or self-esteem, followed by normal alertness upon waking.
 - ii. **Sleep Terror Disorder** is recurrent episodes of abrupt waking from sleep, usually with a panicky scream, without any dream recall or memory of the episode or ability to be calmed, and accompanied by signs of intense fear and autonomic arousal.
 - iii. **Sleep Walking Disorder** is repeated episodes of complex motor behavior initiated during sleep, including rising from bed and walking about, which includes a blank stare, unresponsiveness to the efforts of others to communicate, and amnesia of the episode upon awakening.

3. Discuss that the sleep disorders cause clinically significant distress or impairment in social, occupational, or other areas of functioning.
4. Discuss that the course and prognosis of the specific sleep disorder under consideration, all of which may be quite different from each other and variable.

SLEEP-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in coping with and treating sleep disorders.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

SLEEP-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

SLEEP-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.

2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

SLEEP-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.

SLEEP-L LITERATURE

OUTCOME: The patient/family will receive literature about sleep disorders.

STANDARDS:

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

SLEEP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for coping with sleep disturbances.

STANDARDS:

1. Discuss the good sleep habits that are necessary to optimize sleep and a healthy lifestyle, including:
 - a. maintain regular sleep schedule
 - b. develop a bedtime routine which includes soothing activities

- c. wear comfortable, loose-fitting clothing
 - d. avoid daytime naps
 - e. avoid alcohol, caffeine, nicotine, stimulating night activities, and medications that cause excessive sleepiness or insomnia
 - f. get adequate exposure to bright light during the day
 - g. lose weight, if overweight
 - h. write down concerns and schedule activities each day to avoid excessive worries
 - i. restrict using the bed to activities that promote sleep
 - j. eat a balanced meal with regular mealtimes
 - k. reduce or eliminate sources of light and noise at bedtime, including the TV or light sources
 - l. consider using eye masks or ear plugs as appropriate
 - m. avoid laying in bed for more than 30 minutes if sleep does not occur
 - n. complete soothing activities in soft lighting, e.g., reading, soft music, deep breathing
2. Refer to community services, resources, or support groups, as available.

SLEEP-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

SLEEP-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to sleep disorders.

STANDARDS:

1. Discuss that avoiding caffeine, alcohol, energy drinks, and excessive fluids will promote uninterrupted sleep.
2. Refer to registered dietitian for MNT or other local resources as appropriate.

SLEEP-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of sleep disorders and any co-morbid disorders.

STANDARDS:

1. Review the reason for the initial referral for therapy as part of the care plan.
2. Emphasize that full participation and follow-up are critical to treatment success.
3. Emphasize the importance of openness and honesty with the therapist.
4. Discuss issues of safety, confidentiality, and responsibility.
5. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

SLEEP-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to sleep disorders and the risk of harm to self, both intentional and unintentional.

STANDARDS:

1. Discuss the dangers of occupational, social, or recreational demands, such as driving or operating machinery when diagnosed with a sleep disorder (e.g., narcolepsy).
2. Discuss/review the safety plan with the patient and family, including the no-harm contract and emergency procedures should the condition worsen.
3. Review the local resources and phone numbers, including the police that may be utilized during a crisis, and may assist in transportation and safety compliance.

SLEEP-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in coping with and treating sleep disorders.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in coping with sleep disorders.
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.

SLEEP-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results

- c. how results will impact or effect the treatment plan
- d. recommendations based on the test results

SLEEP-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

SLEEP-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 participation in the treatment plan.
2. Explain that a medication may be prescribed for initial treatment of primary insomnia (**refer to [“SLEEP-M Medications”](#)**).
3. Discuss the role of psychotherapy or alternative treatments to primary sleep disorders, including:
 - a. cognitive behavioral therapy
 - b. hypnosis
 - c. exercise (**refer to [“SLEEP-EX Exercise”](#)**)
 - d. guided imagery
 - e. relaxation and meditation techniques, such as yoga
 - f. biofeedback
 - g. acupuncture
 - h. diet recommendations (**refer to [“SLEEP-N Nutrition”](#)**)
4. Explain that the treatment plan will be made by the patient and treatment team after reviewing the available options.

SNAKE - Snake Bite

SNAKE-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

SNAKE-C COMPLICATIONS

OUTCOME: The patient/family will understand common or serious complications of snake bites.

STANDARDS:

1. Explain that most snakes are non-venomous. Even if a snake is venomous, many bites do not result in envenomation. The most significant risk from non-venomous bites is infection.
2. Explain that the risk from envenomation depends upon the type of the venom (type of snake) and the amount of venom injected. Venom which contains a neurotoxin is generally more dangerous than hemotoxic venom. Mohave rattlesnakes, canebrake rattlesnakes, and coral snakes have venom with a large neurotoxic component.
3. Explain that complications of envenomation may include pain, swelling and bleeding, ecchymosis (purple discoloration), necrosis (tissue dies and turns black), low blood pressure, and tingling of lips and tongue.
4. Explain that even though death from snakebite is unusual, it is still a significant risk and should prompt evaluation by a medical professional.
5. Explain that even if the victim is properly treated, damage to muscles or nerves may result in permanent disabilities or disfigurement.
6. Discuss that some persons may develop phobias or post traumatic stress disorder. Refer to behavioral health. Refer to [“PTSD - Posttraumatic Stress Disorder](#) and [“PHOB - Phobias](#).

SNAKE-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 snakebite.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in the risk and treatment of snakebites. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

SNAKE-DP DISEASE PROCESS

OUTCOME: The patient/family will understand snakebite.

STANDARDS:

1. Explain that although about 7,000 – 8,000 venomous snake bites are reported, only about a dozen people die in the United States each year from snakebites.
2. Discuss the progression of symptoms following snake envenomation:
 - a. Pain at the site of injection
 - b. Local swelling followed by more generalized swelling of the limb
 - c. Dizziness and blurred vision
 - d. Loss of muscle coordination
 - e. Nausea and vomiting
 - f. Numbness and tingling
 - g. Seizures
 - h. Death
3. Explain that in some cases, most of the symptoms are caused by direct damage to blood cells and muscle tissue, but some bites (e.g., Mohave rattlesnakes, canebrake rattlesnakes, and coral snakes) contain a toxin which damages nerves. Neurotoxic venoms are typically more dangerous, but any snake envenomation may cause death.
4. Explain that symptoms are usually more severe if a large amount of venom is injected or if the bite victim is small or frail.

SNAKE-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:

- a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
 - g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
 3. 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.

SNAKE-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

SNAKE-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g. smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.

3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
1. Review the community resources available for help in achieving behavior changes.

SNAKE-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of snakebite.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, as appropriate.

SNAKE-L LITERATURE

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

STANDARDS:

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

SNAKE-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.

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.

SNAKE-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of snake bite.

STANDARDS:

1. Explain that snakebite is best avoided by an awareness of one's surroundings and basic knowledge of snakes' behaviors and habitat.
 - a. Venomous land snakes are found in all U.S. states except Alaska, Hawaii, and Maine.
 - b. Snakes are typically more active during warmer weather.
 - c. Snakes are frequently found under sticks, rocks, or logs. Avoid reaching into a place where you cannot see.
 - d. Most snakebites occur on the hand/arm or the lower leg. Wearing a boot with at least an 8" top of leather or other bite-resistant material can significantly reduce the risk of envenomation.
 - e. Snakes are typically wary of humans and will rarely attack or pursue if left alone.
 - f. A significant percentage of snakebites occurs when someone tries to capture or otherwise antagonize the snake. Alcohol is often involved in this type of situation. Capturing snakes is best left to trained professionals.
2. Discuss the importance of eliminating debris piles and other places attractive to snakes where practical. Emphasize the importance of approaching potential snake habitat, such as fire wood piles, berry patches, hay stacks, etc.

SNAKE-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient; and may be multifaceted. **Refer to ["PM - Pain Management"](#).**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.

4. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
5. Explain non-pharmacologic measures that may be helpful with pain control.

SNAKE-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

SNAKE-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to avoiding snakebite.

STANDARDS:

1. Explain that snakebite is best avoided by an awareness of one's surroundings and basic knowledge of snakes' behaviors and habitat.
 - a. Venomous land snakes are found in all U.S. states except Alaska, Hawaii, and Maine.
 - b. Snakes are typically more active during warmer weather.
 - c. Snakes are frequently found under sticks, rocks, or logs. Avoid reaching into a place where you cannot see.

- d. Most snakebites occur on the hand/arm or the lower leg. Wearing a boot with at least an 8" top of leather or other bite-resistant material can significantly reduce the risk of envenomation.
 - e. Snakes are typically wary of humans and will rarely attack or pursue if left alone.
 - f. A significant percentage of snakebites occurs when someone tries to capture or otherwise antagonize the snake. Alcohol is often involved in this type of situation. Capturing snakes is best left to trained professionals.
2. Discuss the importance of eliminating debris piles and other places attractive to snakes where practical. Emphasize the importance of approaching potential snake habitat, such as fire wood piles, berry patches, hay stacks, etc.

SNAKE-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 (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

SNAKE-TX TREATMENT

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

STANDARDS:

1. Explain that traditional field treatments such as tourniquets, pressure dressing, ice packs, and "cut and suck" snakebite kits are generally ineffective and are possibly dangerous. Splinting the extremity to limit movement and keeping it below the

level of the heart are recommended by many experts and are unlikely to do any harm.

2. Explain that the critical part of the treatment plan is to get the patient to an emergency facility where antivenin can be administered. Walking the victim out is reasonably safe unless severe signs and symptoms occur. It is also significantly faster than trying to carry the victim.
3. Explain that catching and identifying the snake that caused the bite is not as important as rapid transport to the hospital.
4. Explain that there is a significant risk of allergic reaction to the antivenins which are available, but generally the risk is lower than the risk of not treating the snake bite. As appropriate, explain the risk/benefit of treatment and non-treatment.
5. Discuss the importance of maintaining a positive mental attitude.

SOMA - Somatoform Disorders

SOMA-C COMPLICATIONS

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

STANDARDS:

1. Explain that individuals with Somatoform Disorders often seek numerous medical evaluations, diagnostic procedures, surgeries, and hospitalizations, in addition to concurrent treatments with multiple physicians, which often lead to increased risk of morbidity and hazardous combinations of treatment.
2. Explain that symptoms with the disorders many severely disrupt various aspects of daily life, such as family problems, marital discord, unemployment, disability, and social isolation related to the preoccupations, pain, or imagined defects.
3. Explain that most Somatoform Disorders may be associated with substance abuse disorders (refer to [“AOD - Alcohol and Other Drugs”](#)), Delusional Disorders (refer to [“PSYD - Psychotic Disorders”](#)), personality disorders (refer to [“PERSD - Personality Disorder”](#)), depressive disorders (refer to [“DEP - Depressive Disorders”](#)), Obsessive Compulsive Disorder (refer to [“OCD - Obsessive-Compulsive Disorder”](#)), social phobia (refer to [“PHOB - Phobias”](#)), and Panic Disorder (refer to [“PANIC - Panic Disorder”](#)).
4. Explain that Somatoform Disorders often accompany impulsive and anti-social behavior, including suicide threats and attempts (refer to [“SI - Suicidal Ideation and Gestures”](#)).

SOMA-CM CASE MANAGEMENT

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

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”](#).

SOMA-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 health and wellness.

STANDARDS:

1. Discuss the potential differences in the type and frequency of somatic symptoms across cultures. In addition, different cultural groups respond differently to pain and express culturally shaped “idioms of distress” about a broad range of personal and social problems.
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
3. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

SOMA-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and course of Somatoform Disorders.

STANDARDS:

1. Explain that Somatoform Disorders require the presence of physical symptoms that suggest a general medical condition but are not fully explained by a general medical condition or by the direct effects of a substance.
2. Explain that the symptoms of Somatoform Disorders are not intentionally produced or feigned, as seen in Factitious Disorders or Malingering.
3. Explain the essential features of the specific Somatoform Disorder under consideration:
 - a. **Somatization Disorder** includes an extended history of many physical complaints characterized by a combination of four pain symptoms, two GI symptoms, one sexual symptom, and one pseudoneurological symptom or deficit.
 - b. **Undifferentiated Somatoform Disorder** is characterized by unexplained physical complaints that are below the threshold for a diagnosis of Somatization Disorder.
 - c. Conversion Disorder involves unexplained symptoms or deficits affecting voluntary motor or sensory function.

- d. **Pain Disorder** involves pain as the predominant focus of clinical attention, although psychological factors are judged to have a vital role in its onset, severity, exacerbation, or maintenance.
 - e. **Hypochondriasis** is the preoccupation with the fear that one has, a serious disease based on the person's misinterpretation of bodily symptoms or bodily functions, which are not of delusional intensity.
 - f. **Body Dysmorphic Disorder** is the excessively time-consuming preoccupation with an imagined or exaggerated defect in physical appearance.
 - g. **Somatoform Disorder Not Otherwise Specified** includes disorders with somatoform symptoms that do not meet the criteria for any of the specific Somatoform Disorders.
4. Discuss the course and prognosis of the specific Somatoform Disorder under consideration, all of which may be quite different from each other and variable.

SOMA-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in coping with Somatoform Disorders.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

SOMA-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

SOMA-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

SOMA-L LITERATURE

OUTCOME: The patient/family will receive literature about the specific Somatoform Disorder under consideration.

STANDARDS:

1. Provide the patient/family with literature on the specific Somatoform Disorder under consideration.
2. Discuss the content of the literature.

SOMA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for Somatoform Disorder.

STANDARDS:

1. Discuss lifestyle adaptations specific to coping with and/ or over-coming Somatoform Disorders.

2. Discuss that the family may also require lifestyle adaptations to interact with the relative in a healthy manner.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

SOMA-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

SOMA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for Somatoform Disorders.

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.

SOMA-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to Somatoform Disorders.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

SOMA-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

SOMA-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of Somatoform Disorders.

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. Emphasize that full participation and follow-up are critical to treatment success.

4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

SOMA-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to Somatoform Disorders, and the risk of injury or suicide.

STANDARDS:

1. Discuss/review the safety plan with the patient and family, including the no-harm contract and emergency procedures should the condition worsen, suicidal or homicidal ideation arise, and/or urges to engage in impulsive, risky, or dangerous behaviors arise.
2. Review the local resources and phone numbers, including the police, who may be utilized during a crisis, and may assist in transportation and safety compliance.

SOMA-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in coping with Somatoform Disorders.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in coping with Somatoform Disorders.
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.

SOMA-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

SOMA-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

SOMA-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options for Somatoform Disorders.

STANDARDS:

1. Discuss the importance of treating the emotional causes of the symptoms and preventing any unnecessary medical procedures.
2. Explain that therapists have different styles and orientations for treating Somatoform Disorders, and that some styles may suit the patient better than others. Some strategies include:
 - a. Cognitive Behavioral Therapy
 - b. Psychodynamic approaches
 - c. Relaxation, Biofeedback, and stress management techniques
 - d. Behavioral Therapy and Hypnosis
3. Discuss the use of medication in conjunction with psychotherapy in the treatment of Somatoform Disorders (**refer to [“SOMA-M Medications”](#)**):
 - a. Explain that anti-depressant medications are often effective in reducing the pain due to psychological causes.
 - b. Discuss that the use of prescription and non-prescription medication for pain management is usually not effective, and may have serious side effects and potential for addiction.
 - c. Discuss the option for treatment at a pain control center, if available.
4. Discuss the various supportive techniques that may be potentially useful, including hot and cold packs, massage, and physical therapy.
5. Explain that the treatment plan will be made by the patient and treatment team after reviewing available options. Explain that treatment for Somatoform Disorders may vary according to the patient's life circumstances, severity of the condition, the individual's input, and available resources, which may include referrals to inpatient psychiatric hospitals.

ST - Sore Throat (Pharyngitis/Strep Throat)

ST-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

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 that most causes of pharyngitis are self limiting, but some causes such as Group A Beta Hemolytic Streptococcal (GABHS) pharyngitis (i.e., Strep throat) may cause complications, 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-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

ST-DP DISEASE PROCESS

OUTCOME: The patient will understand the pathophysiology and symptoms of pharyngitis.

STANDARDS:

1. Review ways in which pharyngitis 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 strep throat and develops 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 pharyngitis is most often caused by a virus, but can also be caused by bacteria. One bacterial infection is called Strep throat and 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”](#).

ST-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of pharyngitis.

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.

ST-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to pharyngitis.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Discuss the importance of hygiene in infection control, especially in relationship to food preparation/consumption, e.g., don't share eating utensils, plates, cups. Wash all dishes either in the dishwasher or in hot soapy water with bleach.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing. Discuss the importance of using a new tooth brush 24 hours after starting antibiotics.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

ST-L LITERATURE

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

STANDARDS:

1. Provide the patient/family with literature on pharyngitis.
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. Explain that most cases of pharyngitis are caused by viruses and that antibiotics are not effective. Discuss the use of over-the-counter medications, vitamin supplements, and herbal remedies for symptom relief, e.g., decongestants, antihistamines, expectorants.

2. In cases of bacterial infection, such as strep throat, discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation. Explain that failure to complete the entire course of antibiotics increases the patient's risk of developing:
 - a. rheumatic heart disease and rheumatic fever.
 - b. resistant bacteria. **Refer to ["ABX - Antibiotic Resistance"](#).**
3. Describe the name, strength, purpose, dosing directions, and storage of the medication.
4. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.
5. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
6. 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 pharyngitis.

STANDARDS:

1. Explain the importance of good hygiene and infection control principles to prevent the spread of infection.
 - a. covering the mouth when coughing or sneezing
 - b. frequent effective hand washing
 - c. do not share eating utensils, cups, plates, pacifiers, bottle, nipples,
 - d. do not place food-tasting spoons back in food being prepared
 - e. replace with a new toothbrush 24 hours after initiating antibiotics
 - f. wash all dishes in the dishwasher or in hot, soapy water with bleach
2. Discuss the use of surface disinfectants to keep kitchen and bathroom countertops clean. Wash children's toys.
3. If prescribed an antibiotic for a bacterial infection, emphasize the importance of not returning to work, school, or day care until a full 24 hours after initiation of the antibiotic.

ST-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand some ways to control pain associated with pharyngitis.

STANDARDS:

1. Discuss pain management techniques with the patient/family, e.g., gargling with salt water, throat lozenges, and other medications as appropriate.
2. Explain that sometimes medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.

ST-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain the test are used to diagnose strep throat, e.g., throat culture or rapid strep test when infection by this bacteria is suspected. Explain that most cases of pharyngitis will not require testing. Explain as appropriate:
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

ST-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.

3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.

SPIDER - Spider Bite

SPIDER-C COMPLICATIONS

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

STANDARDS:

1. Discuss that the most common complication from spider bites is redness, swelling and irritation of the local tissues which requires only symptomatic care.
2. Discuss that some cases of spider bites result in necrotic arachnidism which results in dead tissue at the site of the spider bite. In rare occasions this may need to be debrided.
3. Explain that spider bites may become infected resulting in cellulitis.

SPIDER-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the body's response to a spider bite.

STANDARDS:

1. Discuss that the toxins released by a spider bite cause tissue inflammation which results in localized swelling, redness, itching and tenderness which is usually self limited.
2. Discuss that the toxins released by spider envenomation can cause significant tissue break-down and may result in a large or small area of tissue necrosis.

SPIDER-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family.
4. Explain signs/symptoms that should prompt immediate follow-up (sloughing of skin, lesion turning back or deep blue, rapidly increasing size of the lesion, systemic symptoms).

SPIDER-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of spider bites.

STANDARDS:

1. Discuss local relief measures for spider bites (ice, anti-inflammatory medications, topical or oral anti-itch medications, etc.).
2. Discuss wound management if debridement of the wound is necessary.

SPIDER-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to spider bites.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.
6. Discuss the importance of not scratching the bite area.

SPIDER-L LITERATURE

OUTCOME: The patient/family will receive literature about spider bites.

STANDARDS:

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

SPIDER-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

SPIDER-P PREVENTION

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

STANDARDS:

1. Discuss seasons or places that spiders are likely to be found.
2. Discuss ways to avoid spider bites.
3. Discuss that professional extermination may be necessary to eliminate spiders from homes or other buildings.

SPIDER-PM PAIN MANAGEMENT

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

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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.

4. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
5. Explain that for simple spider bites, antihistamines, and NSAIDs/acetaminophen are usually sufficient to control the pain associated with the local reaction.
6. Explain non-pharmacologic measures that may be helpful with pain control (such as ice packs)

SPIDER-TE TESTS

OUTCOME: The patient/family will understand 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 (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

SPIDER-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 participation with treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.

SPIDER-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

STING - Sting, Insect

STING-C COMPLICATIONS

OUTCOME: The patient/family will the common and important complications of insect stings.

STANDARDS:

1. Discuss that the most common complication from an insect sting is redness, swelling and irritation of the local tissues which requires only symptomatic care.
2. Discuss that anaphylaxis as a complication of insect sting. Discuss that anaphylaxis generally becomes worse with each exposure to the inciting toxin.
3. Explain that insect stings may become infected especially if scratched.

STING-DP DISEASE PROCESS

OUTCOME: The patient will understand the body's response to an insect sting.

STANDARDS:

1. Discuss that the toxins released by a stinging insect cause tissue inflammation which results in localized swelling, redness and tenderness which is usually self limited.
2. Discuss that some persons become hypersensitized to the toxin and can have a life threatening reaction called anaphylaxis which requires immediate intervention. Symptoms include swelling of the mouth and throat, shortness of breath, chest tightness, and a sense of impending doom.

STING-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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 (swelling of the mouth or tongue, difficulty breathing, etc.).

STING-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of insect stings.

STANDARDS:

1. Discuss importance of always keeping an Epi-Pen near a person with a known history of stinging insect anaphylaxis. Discuss the proper use of an Epi-Pen and the importance of seeking immediate medical attention if the Epi-Pen is needed.
2. Discuss local relief measures for non-anaphylactic stings (ice, anti-inflammatory medications, topical, or oral anti-itch medications, etc.).

STING-L LITERATURE

OUTCOME: The patient/family will receive literature about insect stings.

STANDARDS:

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

STING-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for anaphylactic insect stings.

STANDARDS:

1. Discuss the importance of always keeping an Epi-Pen near a person with a known history of stinging insect anaphylaxis. This is especially true during seasons when the stinging insect is known to be active.
2. Discuss the importance of family members recognizing the signs of anaphylactic insect sting and knowing the proper use of an Epi-Pen as the patient may be incapacitated due to anaphylaxis.
3. Discuss the importance of wearing a medical alert device, if hypersensitive to insect stings.

STING-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. If an Epi-Pen is prescribed demonstrate proper usage of the Epi-Pen.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

STING-P PREVENTION

OUTCOME: The patient/family will understand the measures necessary to prevent being stung by an insect.

STANDARDS:

1. Discuss seasons or places that stinging insects are likely to be found.
2. Discuss the elimination of known bee hives or wasp nests and objects that attract insects, such as flowering plants, sugar drinks/food, hummingbird feeders.
3. Explain that avoiding brightly colored clothing and fragrances decreases the attraction of insects.

STING-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
5. Explain non-pharmacologic measures that may be helpful with pain control (such as ice packs).
6. Explain that for simple insect stings antihistamines and NSAIDs/acetaminophen are usually sufficient to control the pain associated with the local reaction.

STING-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain the test used to diagnose strep throat, e.g., throat culture or rapid strep test. Explain as appropriate:
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

STING-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 participation with treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the use of Epi-Pens as applicable.

STING-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound, e.g., refrain from scratching the site of the insect sting.

SIDS - Sudden Infant Death Syndrome

SIDS-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to SIDS.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with SIDS as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with SIDS, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).**
6. Refer to a mental health agency or provider.

SIDS-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

SIDS-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding SIDS.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding SIDS and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

SIDS-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Discuss measures to prevent SIDS death.
 - a. Explain that placing baby on the back to sleep at all times is the safest position for a healthy baby and may help reduce the risk of SIDS death.
 - b. 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 monitored and is important for infant development and will make neck and shoulder muscles stronger. Remember, "Back to Sleep, Tummy to Play."
 - c. 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 stomachs and have an increased risk of SIDS.
2. Explain that when a baby sleeps only in the back position, some flattening of the back of the head may occur.
 - a. Explain that flattening of the head is not harmful or associated with any permanent effects on head size and go away a few months after the baby learns to sit up.
 - b. Explain that flattening of the head can be prevented by alternating the head of the bed to the foot of the bed on alternate nights.
3. Encourage the client to be receptive to home visits by public health nurses because home visits have been associated with a lower risk of SIDS deaths.
4. Discuss that maternal smoking has been shown to increase the risk of SIDS.

SIDS-I INFORMATION

OUTCOME: The parents/family will understand what SIDS is and factors that are associated with the increased risk of SIDS.

STANDARDS:

1. Explain SIDS.
 - a. Explain that SIDS stands for Sudden Infant Death Syndrome and also may be called crib death.

- b. Explain that SIDS 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 and is unique.
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. Factors include: sleeping positions e.g., stomach and side sleeping, exposure of infants to cigarette smoke, maternal smoking, and overheating baby while sleeping with too much clothing and/or bedding.
5. Encourage avoidance of alcohol use anytime, especially in the first trimester of pregnancy.

SIDS-L LITERATURE

OUTCOME: The parent(s) and family will receive literature about SIDS.

STANDARDS:

1. Provide the patient/family with literature on SIDS.
2. Provide the patient/family with literature on smoking cessation.
3. Discuss the content of the literature.

SIDS-P PREVENTION

OUTCOME: The parents/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

OUTCOME: The parents/family will understand that even though there is no way to know which babies that SIDS may affect, however, there are measures that can be taken to make the baby safer.

STANDARDS:

1. Emphasize the safest place for a baby to sleep is in a crib on and firm mattress.
 - a. Discuss that placing a baby to sleep on soft surfaces can increase the risk of SIDS, e.g., mattresses, sofa cushions, and waterbeds.
 - b. Explain hazards in letting babies sleep on adult beds, e.g., falls, suffocation, and getting trapped between the bed and wall.
 - c. Explain that beds are not designed to meet safety standards for infants.
2. Discuss infant overheating.
 - a. Discuss potential hazards of overheating.
 - b. Encourage sleep clothing such as an infant sleeper or a wearable blanket, so no other covering is needed (use no more than 2 layers of clothing).
 - c. Encourage a sheet or thin blanket. Tuck it in reaching only as far as the baby's chest. The room temperature should be comfortable.
3. Explain that the risk of SIDS is decreased when a pacifier is used during infant sleep.
 - a. Encourage patient to consider offering a pacifier at nap time and bedtime.
 - b. Explain that a pacifier should not be used after the infant falls asleep.
 - c. For breastfed babies, the pacifier should be delayed until one month of age to ensure breastfeeding is firmly established.
 - d. Discuss methods of cleaning pacifier and that it should be changed frequently.

SIDS-SHS SECOND-HAND/THIRD-HAND SMOKE

OUTCOME: The parents/caregiver will understand the adverse health consequences associated with exposure to second-hand and third-hand tobacco smoke.

STANDARDS:

1. Explain that second-hand smoke is known as "passive smoking." Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand

smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.

2. Discuss harmful substances in smoke, e.g., nicotine, benzene, carbon monoxide, lead, and many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness when exposed to cigarette smoke either directly or via second-hand/third-hand smoke.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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-OT Quit.](#)**

SIDS-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in dealing with SIDS death.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in SIDS deaths.
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.

SI - Suicidal Ideation and Gestures

SI-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications to suicide and suicidal ideation.

STANDARDS:

1. Explain that the most obvious and tragic complication to suicidal ideation and gestures is death, especially when SI and associated depression are left untreated or when the individual is disinhibited under the influence of drugs and alcohol.
2. Explain that suicidal ideation and attempts often create emotional upheaval in the extended family system, and that completed suicides may result in cluster suicides among family, friends, and community members.
3. Explain that suicidal ideation usually reflects an underlying emotional or mental disorder, and that intrusive thoughts of suicide may be disturbing or debilitating to both the patient and families, and may interfere with normal daily functioning.
4. Explain that suicidal gestures and attempts can result in unforeseen physical and medical injuries due to incomplete suicides, including brain damage and organ failure from surviving gunshot wounds, drug toxicity, and hanging.

SI-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in treatment and follow-up for suicidal ideation.

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”](#).

SI-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Discuss any conflict that may exist regarding traditional beliefs regarding suicide, including taboos around discussing the topic. Discuss ways of addressing suicide in a culturally appropriate manner.
3. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

SI-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the origins and process of suicidal ideation, gestures, and behaviors.

STANDARDS:

1. Discuss that suicidal thoughts rarely arise outside the context of other diagnoses, such as depression or substance abuse. In fact, suicidal ideation is a common symptom of major depressive disorder, manic episodes, and psychosis.
2. Explain that suicidal thoughts come and go, and may be exacerbated by internal or external stressors, by substance abuse, or by another mental health condition.
3. Explain that thoughts of suicide is always a concern, even if not acted upon, and needs to be addressed with a mental health professional.
4. Explain that suicidal gestures, such as cutting, burning, or carving one's own skin, although not always intentionally suicidal in nature, share the same underlying mechanisms and etiologies, progress over time, and have the same potentially dangerous outcome.

SI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up after any instances of experiencing suicidal ideation and gestures.

STANDARDS:

1. Explain that suicidal ideation rarely, if ever, goes away without treatment, and that these thoughts need to be addressed by a mental health profession as soon as possible. Emphasize the importance of follow-up care, even the suicidal thoughts temporarily subside.
2. Discuss the procedure and process for obtaining follow-up appointments.

3. Discuss the importance of outpatient follow up after discharge from psychiatric hospital.
4. Discuss signs/symptoms that should prompt immediate follow-up, including warning signs (**refer to [“SI-P Prevention”](#)**).
5. Discuss the availability of community resources and support services and refer as appropriate.

SI-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help/crisis intervention line.

STANDARDS:

1. Explain that a help/crisis intervention line may assist in dealing with an immediate crisis.
2. Provide the help/crisis intervention line phone number and hours of operation, such as a local crisis hotline or the national hotline 1-800-.273-TALK or www.suicidepreventionlifeline.org.
3. Explain how the help/crisis intervention line works and what can be expected from calling and/or participating in the services.

SI-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high-risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

5. 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.

SI-IR INFORMATION AND REFERRAL

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

STANDARDS:

1. Provide patient/family with alternative or additional sources for care and services, including referral to a mental health professional.
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

SI-L LITERATURE

OUTCOME: The patient/family will receive literature about suicidal ideation and gestures.

STANDARDS:

1. Provide the patient/family with literature on suicidal ideation and gestures.
2. Discuss the content of the literature.

SI-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. Discuss any black box warnings and the potential for temporary, increased thoughts of suicide that may arise with SSRIs prescribed for depression.

3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

SI-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of acting on suicidal ideation.

STANDARDS:

1. Discuss the importance of removing all means of committing suicide, including firearms, knives, and other weapons, as well as dangerous medications. Discuss the importance of finding a family member or friend to hold any medications that have potential for overdose, and to give them daily to the patient as prescribed.
2. Explain the importance of treating the underlying condition or the suicidal thoughts will likely return repeatedly in the future.
3. Explain the warning signs and risk factors of depression and suicidal ideation, the need for the patient and family to become familiar with them, and to seek help accordingly. These warning signs and risk factors include:
 - a. Talking about suicide
 - b. Stockpiling medications or obtaining weapons
 - c. History of previous suicide attempts or presence of a mental health diagnosis
 - d. Changes in behavior, including social isolation, increased use of alcohol and drugs, changes in sleeping or eating routines, mood swings
 - e. Giving away belongings or saying "goodbye" to friends and family as if for the last time
 - f. Risky or self-destructive behaviors
 - g. Poor eye contact, and unusual and excessive crying spells
4. Help the patient to gain awareness of thoughts and control over behaviors:
 - a. Discuss the difference between having thoughts and acting on them.
 - b. Explain that suicidal ideation is often accompanied by distortions in thinking and beliefs, such as believing that one's family would be better off without the patient or that one's problems will continue to worsen throughout life.

- c. Encourage the patient to seek help when suicidal thoughts arise, including police, emergency room visits, safety contracts, and suicide hotlines (**refer to [“SI-HELP Help Line”](#) and [“SI-S Safety”](#)**).
 - d. Discuss the danger of hurting one’s self out of anger, especially during adolescence.
5. Reassure the patient. Reinforce the fact that the patient is not alone and can be helped.

SI-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in coping with suicidal ideation and gestures.

STANDARDS:

1. Explore the origins and dynamics of the suicidal ideation, and the associated factors that need to be addressed in the psychotherapy.
2. Explain that therapy may include individual, group, psycho-educational / therapeutic, talking circles, or other modalities.
3. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

SI-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to suicidal ideation and gestures.

STANDARDS:

1. Discuss the safety plan/contract with the patient, including no-harm contract and local resources and phone numbers, in case the condition worsens or the urge to hurt oneself increases.
2. Discuss the potential and process of voluntary or involuntary hospitalization should the patient have difficulties staying safe or refraining from acting on the impulses to hurt oneself.
3. Explain that local police may also be available to assist in transportation and safety compliance.

SI-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in suicidal ideation and gestures.

STANDARDS:

1. Explain that effective stress management may help reduce the severity of the symptoms of depression and of suicidal behavior.
2. Explain seeking professional help to improve the health and well-being of the patient is often necessary.
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 severity of the depression or the risk of suicidal/homicidal behaviors.
4. 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. Recruiting family members or friends as a support system
 - d. Talking with people you trust about your worries or problems
 - e. Setting realistic goals
 - f. Getting enough sleep
 - 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
5. Provide referrals as appropriate.

SI-TX TREATMENT

OUTCOME: The patient/family will have an understanding of the treatment options for suicidal thoughts and behaviors, as well as any underlying conditions.

STANDARDS:

1. Explain the treatment for suicidal ideation is usually directed toward associated conditions, including depression (**refer to [“DEP-TX Treatment”](#)**), bipolar

disorder (refer to [“BD-TX Treatment”](#)), substance abuse (refer to [“AOD-TX Treatment”](#)), or psychosis ([“PSYD-TX Treatment”](#)).

2. Discuss that there may be an initial crisis stabilization period followed by a longer period of psychotherapy and lifestyle adjustments. Discuss the potential and process of voluntary or involuntary hospitalization should the patient have difficulties staying safe or refraining from acting on the impulses to hurt oneself.
3. Explain that a combination of psychotherapy and medication interventions usually has better results than therapy or medication alone. The patient has a right to choose either option or both, and that the patient's active participation in the treatment decisions is critical to a good outcome.
4. Explain that therapists have different styles and orientations for treating suicidal ideation and the underlying conditions, and that no one approach has been shown to be more effective than others, although some styles may suit the patient better.

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 five ABCDE 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
 - e. Evolving - changes over time in size, color, shape, or signs and symptoms, such as new itchiness or bleeding
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](#).**
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](#).**
 - 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°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.**](#)

SUP - Supplements, Nutritional/Herbal

SUP-C COMPLICATIONS

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

STANDARDS:

1. Discuss common complications of excessive use of supplements or functional foods.
 - a. Explain that excessive use of vitamins, minerals, or other supplements may have toxic effects.
 - b. Explain that vitamin and/or mineral supplements may interfere with medications.
2. Discuss signs/symptoms of toxicity as it relates to the patient's supplement regimen.
3. Explain that it is important to inform your doctor about any medications, vitamins, minerals, and other supplements you are taking.
4. Refer to registered dietitian, 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes

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 with vitamins and minerals but may also contain 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. Discuss supplements which may be appropriate for this patient's disease state, condition, or medication regimen, including any supplements that may be contraindicated in this disease state, condition, or medication regimen.

SUP-L LITERATURE

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

STANDARDS:

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

SUP-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 importance of following the prescribed timing of supplements in regard to other foods and medications.
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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
6. 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.

SUP-MNT MEDICAL NUTRITION THERAPY

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

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 nutrition, as it relates to nutritional supplements.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake.
4. Explain that oral supplements are beneficial if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

SUP-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to supplements.

STANDARDS:

1. Discuss the use of supplements with physician before combining or substituting them with other foods or 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 the use, interactions, and indications of supplements.
4. Explain that unlike drugs, dietary supplements are not approved by the FDA for safety and effectiveness.
5. Discuss the USP-verified supplements indicate 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.

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 many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is unable to provide guidance at the time that decisions need to be made.
3. Explain that Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences for care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer,) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.
6. Refer to ["ADV - Advance Directives"](#).

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 that 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. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

SPE-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

SPE-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in surgical procedures and endoscopy.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

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”](#).**
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: The 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: The patient/family will be prepared for surgery or other procedure.

STANDARDS:

1. Explain the pre-operative preparation, e.g., bathing, bowel preps, diet instructions, smoking cessation, discontinuation of certain medications.
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. Emphasize the importance of hand hygiene before and after caring for the surgical site and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
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 verify the proposed surgery and participate in marking the surgical site.
6. Discuss what to expect after the procedure, including pain management, as appropriate.

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, and 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections

5. Discuss pain management as appropriate.
6. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.

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. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

SYN - Syncope

SYN-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

SYN-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the syncope.

STANDARDS:

1. Discuss that syncope is the most common cause of fainting.
2. Explain that syncope is a sudden, usually temporary, loss of consciousness generally caused by insufficient oxygen to the brain either through cerebral hypoxia or through hypotension, but possibly for other reasons.
3. Explain that pooling of blood in the legs also results in a decrease in blood pressure.
4. Explain that the symptoms that may precede syncope may include:
 - a. pale appearance of the skin
 - b. nausea
 - c. light-headedness
 - d. feeling of warmth
 - e. cold, clammy sweat
 - f. confusion or disorientation
5. Explain that the body reacts in an exaggerated way to triggers that result in syncope. Explain that the common triggers for syncope may include:
 - a. standing for long periods of time
 - b. heat exposure
 - c. low blood sugar
 - d. unpleasant sights or smells
 - e. having blood drawn or getting shots

- f. fear of bodily injury
- g. during urination, defecation, or coughing
- h. intense emotion or pain
- i. hyperventilation

SYN-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

SYN-EX EXERCISE

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

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

SYN-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

SYN-L LITERATURE

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

STANDARDS:

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

SYN-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for recurrent syncope.

STANDARDS:

1. Discuss lifestyle adaptations specific to recurrent syncope.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Explain that if the patient feels an episode of syncope is presenting, the patient should be instructed to lie down and lift the legs or sit and put the head between the legs.
5. Refer to community services, resources, or support groups, as available.

SYN-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

SYN-P PREVENTION

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

STANDARDS:

1. Discuss the identifying warning signs of syncope. Refer [“SYN-DP Disease Process”](#).
2. Explain that if the patient feels an episode of syncope is presenting, the patient should be instructed to lie down and lift the legs or sit and put the head between the legs.
3. Explain the importance of staying hydrated or avoiding long periods of standing.
4. Discuss strategies to avoid low blood sugar.

SYN-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.

4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

SYN-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to syncope.

STANDARDS:

1. Discuss strategies to prevent injuries as a result of syncope.
2. Explain that the patient may fall unexpectedly.
3. Discuss driving or operating other types of equipment if syncope is recurrent.

SYN-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in syncope.
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.

SYN-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

SYN-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
 - a. foot exercises to prevent pooling of blood in the legs
 - b. wearing elastic stockings
 - c. tensing leg muscles while standing
 - d. avoiding prolonged standing especially in hot, crowded place
 - e. drinking plenty of water

3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

T**TICD - Tic Disorders****TICD-C COMPLICATIONS**

OUTCOME: The patient/family will understand the potential complications to tic disorders.

STANDARDS:

1. Explain that tic disorders are frequently associated with social discomfort, shame, self-consciousness, and depressed mood, which may impair academic, occupational, or social functioning because of rejection by others or anxiety about having tics in social situations.
2. Discuss that the most common complications of Tourette's Disorder are obsessions and compulsions, and that hyperactivity, distractibility, and impulsivity are also relatively common.
3. Explain that tics may directly interfere with daily activities, such as reading and writing.
4. Discuss that rare complications of Tourette's Disorder include physical injury, such as blindness due to retinal detachment (from head banging or striking oneself), orthopedic problems (from knee bending, neck jerking, or head turning), and skin problems (from picking).
5. Explain that Obsessive-Compulsive Disorder (**refer to ["OCD - Obsessive-Compulsive Disorder"](#)**), Attention-Deficit/ Hyperactivity Disorder (**refer to ["ADHD - Attention-Deficit/Hyperactivity Disorder"](#)**), and Learning Disorders (**refer to ["LD - Learning Disorders/Disabilities"](#)**) may be associated with Tourette's Disorder.

TICD-CM CASE MANAGEMENT

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

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"](#).**

TICD-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

TICD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the symptoms and the course of the tic disorder.

STANDARDS:

1. Explain that tic disorders are neurological disorders characterized by sudden, rapid, recurrent, nonrhythmic, stereotyped motor movements or vocalizations that cannot be controlled, although they sometimes can be suppressed for varying lengths of time. Describe the different types of tics:
 - a. Common **simple motor tics** include eye blinking, neck jerking, shoulder shrugging, facial grimacing, and coughing.
 - b. Common **simple vocal tics** include throat clearing, grunting, sniffing, snorting, or barking.
 - c. Common **complex motor tics** include facial gestures, grooming behaviors, touching, jumping, stamping, and smelling an object.
 - d. Common **complex vocal tics** include repeating words or phrases out of context, coprolalia (use of socially unacceptable, and frequently obscene words), palilalia (repeating one's own sounds or words), and echolalia (repeating the last sound, word, or phrase).
2. Explain the symptoms and course of the tic disorder under consideration:
 - a. **Tourette's Disorder** is the most severe, and is diagnosed when both multiple motor tics and one or more vocal tics have been present (although not necessarily concurrently) nearly every day or intermittently for over one year and without a tic-free period of more than 3 consecutive months.
 - b. **Chronic Motor or Vocal Tic Disorder** is diagnosed when single or multiple motor or vocal tics, but not both, have been present nearly every day or

- intermittently for over one year and without a tic-free period of more than 3 consecutive months.
- c. **Transient Tic Disorder** is diagnosed when single or multiple motor and/or vocal tics are present nearly every day for at least 4 weeks, but no longer than 12 consecutive months.
 - d. **Tic Disorder Not Otherwise Specified (NOS)** is diagnosed for individuals who experience tics, but do not meet criteria for a specific tic disorder.
3. Explain that stress, anxiety, and certain physical acts, including writing, may exacerbate or trigger tics. Explain that CNS stimulants may exacerbate the severity of tics.
 4. Explain that tic disorders are hereditary and involve a genetic vulnerability or predisposition, specifically an autosomal dominant disorder. Explain that tic disorders are neither a progressive nor degenerative disorder; rather, symptoms tend to be variable and follow a chronic waxing and waning course throughout an otherwise normal life span. The duration of the disorder is life-long, although treatment may help to reduce the frequency and severity of tics.
 5. Explain that the diagnosis requires the age of onset must be before 18 years old, and that the disorder causes marked distress or impairment in social, occupational, or other important area of functioning.
 6. Explain that tic disorders are not due to the direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington's disease).

TICD-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in treating and coping with tic disorders.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
3. Discuss obstacles to a personal physical activity plan, including the risk of triggering tics, and potential solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

TICD-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of tic disorders and associated conditions.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

TICD-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding tic disorder.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding tic disorder and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

TICD-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

TICD-L LITERATURE

OUTCOME: The patient/family will receive literature about tic disorders.

STANDARDS:

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

TICD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for adjusting to tic disorders, and improving treatments.

STANDARDS:

1. Discuss lifestyle adaptations for the patient and family specific to tic disorders that may help to reduce the frequency and severity of tics:
 - a. Learn stress management techniques to reduce the anxiety that may exacerbate tics. **Refer to [“TICD-SM Stress Management”](#).**
 - b. Notice when the patient’s tics get worse, write them down to track them and help identify triggers, and ultimately help the patient work through or avoid them. Try to do so without creating more stress for the patient.
 - c. Don’t treat tics of the family member as willful behavior, remember that tics cannot be controlled, and learn methods to cope with the frustrations that they cause.
 - d. Alternate household tasks with free time.
 - e. Reassure a family member by remaining calm and helping the patient to relax.
 - f. Parents can encourage a child with a tic disorder to increase responsibilities only at the patient’s own pace.
 - g. Parents may collaborate with teachers to develop accommodations at school, including more time for tests, provide a seat with little distraction and some privacy, allow for frequent rest periods when needed, allow patient to leave room if necessary to allow the tics to occur in private, and finding teachers who discourage teasing by responding quickly and firmly whenever it occurs.
 - h. Set a good example of accepting the family member with the tic disorder.
 - i. Provide tutoring, learning laboratories, or special classes, if needed.
 - j. Join the psychotherapy with the patient to help meet the treatment goals.
2. Discuss ways to optimize quality of life.
3. Refer to community services, resources, or support groups, as available.

TICD-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

TICD-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy in the treatment of tic disorders and associated conditions.

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. Emphasize that full participation and follow-up are critical to treatment success.
4. Emphasize the importance of openness and honesty with the therapist.
5. Discuss issues of safety, confidentiality, and responsibility.
6. Explain to the patient that the therapist and the patient will establish goals and duration of therapy together.

TICD-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in reducing the frequency and severity of tics.

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect, and possibly trigger tics.

2. Explain the role of effective stress management in reducing the frequency and severity of tics.
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.

TICD-TLH TELE-HEALTH

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

STANDARDS:

1. Explain that tele-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 that informed consent must be obtained. Explain that patients are free to refuse tele-health services; however, there may not be any other services available.
3. Discuss the process of tele-health including the use of telecommunication equipment, the role of the distant consulting clinician, the 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).

TICD-TX TREATMENT

OUTCOME: The patient/family will understand the treatment options for tic disorders.

STANDARDS:

1. Explain that there is currently no cure for tic disorders, and that treatment for tic disorders is focused on managing tics and helping the patient and family to cope with them.
2. Explain that most individuals with tic disorders have mild cases that may not require treatment, but simply may require extra support or accommodations to reduce the potential of triggering tics, such as more time to complete school tests.
3. Explain that patients often require treatment of associated conditions, such as depression (refer to [“DEP-TX Treatment”](#)), Obsessive- Compulsive Disorder (refer to [“OCD-TX Treatment”](#)) or Attention-Deficit/ Hyperactivity Disorder (refer to [“ADHD-TX Treatment”](#)), which may exacerbate the severity and frequency of tics.
4. Explain that therapists have different styles and orientations for treating TICD, and that no one approach has been shown to be more effective than others, although some styles may suit the patient better.
 - a. Explain that behavioral therapies, such as habit reversal, may be useful in reducing tics in severe cases.
 - b. Explain that medications may be useful for some individuals in reducing frequency and severity of tics. Explain that decisions about timing and duration of medication will be made jointly by the provider(s) and the patient/parents.
5. Explain that active participation in the treatment by the patient and family is required for the identification of specific target problems that need to be addressed in therapy, which may vary from one environment to the other, such as home and school.
6. Explain the lifestyle changes that are an important part of treatment (refer to [“TICD-LA Lifestyle Adaptations”](#)).

TO - Tobacco Use

TO-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain that tobacco use alters the normal anatomy and physiology of the entire body, including the fetus of a pregnant woman.
2. Discuss the changes to anatomy and physiology as a result of tobacco.
 - a. When a person inhales cigarette smoke, the nicotine in the smoke is rapidly absorbed into the blood and starts affecting the brain. The result is the release of adrenaline. Adrenaline increases a person's heart rate, blood pressure, and restricts blood flow to the heart muscle. When this occurs, the smoker experiences rapid, shallow breathing, and the feeling of a racing heartbeat. Adrenaline also instructs the body to dump excess glucose into the bloodstream.
 - b. The nicotine in tobacco moves from the lungs or the gums, into the bloodstream and then on to harm various organs and systems within the body. Within 7-10 seconds after inhaling, the nicotine triggers a number of chemical reactions in the brain that create temporary feelings of pleasure for the tobacco user.
3. Discuss the impact of these changes on the patient's health or well-being.

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, numerous kinds of cancers including lung cancer, increased risk of neuropathy, cardiovascular disease, dental disease, impotence, infertility, lower healing rate, placental insufficiency, low birth weight, and fetal demise.
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., second-hand smoke, tobacco use increases the risk for SIDS deaths, financial burden, greater risk of house fires, motor vehicle accidents, 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/Third-Hand Smoke”](#).**
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. Encourage the patient to understand the difference between the cultural aspects of tobacco while recognizing the potential for the abuse of commercial tobacco. Tobacco has been used for many generations as offerings to the spirits, for planting, for gathering food, as a medicine for healing, and for ceremonies. The sacred uses of tobacco are different for many tribes but a basic truth remains, tobacco should only be used for prayer, protection, respect, and healing.
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. Explain that tobacco use harms nearly every organ of the body, causes many diseases, and reduces the health of smokers in general because cigarettes, chewing tobacco, and other tobacco products contain many harmful chemicals. **[“TO-C Complications”](#)**. Examples of harm from tobacco use include:
 - a. Smoking increases the carbon monoxide levels; carbon monoxide is harmful to the body and increases the chance of cardiovascular diseases.
 - b. Smoking reduces the oxygen levels in the body.
 - c. Tobacco use causes destruction of the nerve ending.
 - d. Nicotine also inhibits the release of insulin from the pancreas, a hormone that is responsible for removing excess sugar from a person’s blood. This leaves the smoker in a slightly hyperglycemic condition.
2. Explain nicotine addiction. Discuss that nicotine is rapidly addictive and an exceedingly difficult addiction to break.

- a. Nicotine activates the same reward pathways in the brain that other drugs of abuse do, such as cocaine or amphetamines.
 - b. Nicotine increases the level of dopamine in the brain, a neurotransmitter that is responsible for feelings of pleasure and well-being. The acute effects of nicotine wear off within minutes, so people must continue dosing themselves frequently throughout the day to maintain the pleasurable effects of nicotine and to prevent withdrawal symptoms.
3. Explain that most patients require many 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 that moderately intense exercise may help patients better cope with tobacco withdrawal symptoms and may be useful as an aid to smoking cessation. Exercise can also reduce restlessness, stress, tension, and poor concentration after exercise.
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, and the risk of relapse, prevalence, and prevention techniques. Refer to the 5A Approach (Ask, Advise, Assess, Assist, Arrange).

STANDARDS:

1. Emphasize the importance of maintaining contact for follow-up care. Tobacco cessation requires support from healthcare providers, family, and friends.
2. Review the health benefits of long-term cessation and discuss the personal reasons/motivations for quitting.
3. Schedule follow-up visits to review progress toward quitting. If a relapse occurs, encourage the patient to repeat the quit attempt. Review the circumstances that caused relapse. Use relapse as a learning experience.

4. Discuss the risks related to relapse (e.g. depression, weight gain, alcohol use, stress, traumatic life events, contact with other tobacco users) and provide support for managing these risks. Explain that more frequent follow-up is recommended during the first six months of tobacco cessation.
5. Review medication use and side effects, and discuss signs/symptoms that should prompt immediate follow-up.
6. Discuss the availability of community resources and support services and refer as appropriate.

TO-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a telephone tobacco help line, also known as a quit line. Refer to the 5A Approach (Ask, Advise, Assess, Assist, Arrange).

STANDARDS:

1. Explain to the patient/family that a help/quit line will enable the patient to talk with a specialist who can help in choosing an individualized tobacco use quit plan which may include various types of treatment such as group or individual counseling and/or medications.
2. Explain that people who use telephone counseling stop using tobacco at a much higher rate than those who don't get this type of help.
3. Provide the patient with the help/quit line phone number and hours of operation or assist the patient in calling the quit line during the patient encounter. Recommend toll free 1-800-QUIT NOW (1-800-784-8669), the national access number to state-based quit line services.
4. Explain how the help/quit line works and what the patient can expect from calling and/or participating in the services.

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. Explain that tobacco use can lead to older appearance, wrinkles on the skin, bad breath, stained teeth, and a bad smell on clothing.
3. Review bathing, dental hygiene, and laundry/house cleaning (to reduce tobacco residue/odor).
4. Review the importance of daily dental hygiene, with attention to brushing and flossing.

5. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.

TO-IR INFORMATION AND REFERRAL

OUTCOME: The patient/family will understand the process of referral and treatment for nicotine dependence. Refer to the 5A Approach (Ask, Advise, Assess, Assist, Arrange).

STANDARDS:

1. Discuss sources for tobacco cessation treatment.
2. Refer to nicotine treatment program or other resource as available.
3. Recommend toll free 1-800-QUIT NOW (1-800-784-8669), the national access number to state-based quit line services.

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 and ways to change the behavior that will help the patient to resist the urge to use tobacco.
2. Discuss tips for stress relief and "healthy replacement habits." Learn new skills and behaviors to relieve the stress of addiction:
 - a. get rid of things that makes the patient think about using tobacco
 - b. throw away cigarettes, lighters, and ashtrays
 - c. do things to take the mind off tobacco
 - d. engage in moderately strenuous exercise
 - e. take a walk or call a friend when there is the urge to use tobacco
 - f. try to lower stress and stay relaxed

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 common medications for tobacco cessation: nicotine replacement (patch, gum lozenge, nasal spray) and other prescription medications.
 - 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

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.
 - a. Change in social networks, living arrangements, school, and work settings increase susceptibility to tobacco use.
 - b. Caution patients that even experimental tobacco use can become addictive because as we grow and our lives change, we face changes in our lives such as relationships, parenthood, jobs - and tobacco may either be rejected or become an established addiction.
 - c. Parents should serve as good role models for their children. Children of parents who use tobacco will most likely use tobacco also.
2. Discuss methods (as appropriate to this patient) to avoid ever using tobacco.

TO-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care.

STANDARDS:

1. Discuss how health and lifestyle factors influence reproductive health and childbearing.
 - a. intake of adequate folic acid, calcium and vitamin D
 - b. avoid tobacco exposure
 - c. encourage tobacco cessation, if applicable

- d. avoid alcohol or other drugs
 - e. stay safe from violence (i.e., Intimate Partner Violence or Domestic Violence)
 - f. attain a healthy weight before conception.
 - g. stay current on immunizations
 - h. limit exposure to occupational hazards
 - i. screening and treatment for STIs, including HIV
2. Discuss the importance of managing chronic conditions (i.e., obesity, thyroid, blood pressure, diabetes, oral health) during preconception and pregnancy in planning to reduce risk of birth defects and complications.
 3. Discuss the need to review all prescription and OTC medications including herbal products with a provider or pharmacist.
 4. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies
 - f. childcare
 5. Refer for medical and psychosocial support services for any risk factor identified.

TO-REL RELAPSE PREVENTION

OUTCOME: The patient/family will understand the risk of relapse prevalence and relapse prevention techniques.

STANDARDS:

1. Explain that every ex-tobacco user will receive congratulations on any success (duration of abstinence) and strong encouragement to remain abstinent.
2. Review the health benefits of long-term cessation for patient/family/friends and remind them of their personal reasons/motivations for quitting, (e.g., depression, weight gain, alcohol use, stress, traumatic life events, other commercial tobacco users in the household).
3. Remind the patient/family that commercial tobacco users who have failed previous quit attempts may need to make repeated quit attempts before they are successful (resources -USPHS Guidelines and Native Communities Certification (I.H.S. TCTF & UofA) Guidebook).

TO-QT QUIT

OUTCOME: The patient/family will understand that tobacco cessation will improve quality of life, that cessation will benefit health, and how participation in a support program may prevent relapse. Refer to the 5A Approach (Ask, Advise, Assess, Assist, Arrange).

STANDARDS:

1. Advise all tobacco users to quit using tobacco and advise all non-tobacco users to continue to abstain from tobacco use.
2. Ask if the tobacco user is willing to quit at this time.
 - a. If the patient is willing, set a quit date, ideally within 2 weeks.
 - b. If unwilling to quit at this time, help motivate the patient:
 - i. identify reasons to quit in a supportive manner
 - ii. build patient's confidence about quitting
 - iii. encourage the patient to remove tobacco products from the environment and to get support from family, friends, and coworkers
 - iv. review past quit attempts—what helped, what led to relapse
 - v. anticipate challenges, particularly during the critical first few weeks, including nicotine withdrawal and cravings
 - vi. identify reasons for quitting and benefits of quitting
 - c. If the patient is not using tobacco, reinforce abstinence and/or cessation from tobacco use by promoting the health benefits of not using tobacco.
3. Discuss that readiness and personal motivation are key components to abstaining from tobacco and quitting. Review the treatment, medication, and support options available to the patient/family. Make referrals as appropriate. Give advice on successful quitting:
 - a. total abstinence is essential—not even a single puff
 - b. drinking alcohol is strongly associated with relapse
 - c. allowing others to smoke in the household hinders successful quitting
 - d. discuss the risks and benefits of prescription medications and nicotine replacement to increase chances of quitting (**refer to [“TO-M Medications”](#)**)
4. Review the value of frequent follow up and support during the first six months of cessation.

TO-S SAFETY

OUTCOME: The patient/family will understand safety issues as they apply to tobacco use.

STANDARDS:

1. Discuss that smoking in bed or falling asleep while smoking greatly increases the risk of house fires:
 - a. emphasize to never smoke while in bed or if sleepy
 - b. emphasize the importance of smoke alarms in the home but especially in areas where the smoking most occurs
2. Discuss the risk of cigarette burns.
3. Discuss that smoking while driving is a distraction and increases the risk of motor vehicle crash.
4. Emphasize the need for good hygiene in the cleanliness of the home; toddlers and pets may ingest tobacco butts, “spit cups” contents, or the residue on clothing, bedding and upholstery.
5. Discuss that tobacco smoke is an indoor air pollutant and can affect children and adults with respiratory and other chronic conditions.

TO-SHS SECOND-HAND/THIRD-HAND SMOKE

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

STANDARDS:

1. Explain that second-hand smoke is known as “passive smoking.” Second- and third-hand smoke are the ways in which tobacco exposure occurs: second-hand smoke is inhaling the tobacco smoke of a cigarette while third-hand tobacco is the tobacco residue that remains on clothing, carpet, upholstery.
2. Discuss harmful substances in smoke e.g., nicotine, benzene, carbon monoxide, lead, 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, SIDS, and lung cancer.
4. Discuss requesting household members to smoke outside of the home and outside of the car. Ceasing to smoke in the home and family vehicles will help to decrease exposure to second- and third-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-OT Quit”](#).**

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.
2. 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.
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.

TB - Tuberculosis

TB-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to tuberculosis.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with tuberculosis as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with tuberculosis, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs](#).**
6. Refer to a mental health agency or provider.

TB-C COMPLICATIONS

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

STANDARDS:

1. Discuss common complications of tuberculosis.
2. Describe the signs/symptoms of common complications of tuberculosis.

TB-CM CASE MANAGEMENT

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

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.”](#)

TB-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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). **Refer to [“AOD - Alcohol and Other Drugs](#).**
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.

TB-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
3. Emphasize that full participation in the treatment plan is the responsibility of the patient/family. Discuss the consequences of non-participation.
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding tuberculosis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding tuberculosis and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

TB-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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 will 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-SCR SCREENING SKIN TEST

OUTCOME: The patient/family will understand the importance of screening and follow-up and the meaning of the result of PPD test.

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, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

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-AP ANATOMY AND PHYSIOLOGY**

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

STANDARDS:

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

UC-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components to ulcerative colitis.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with ulcerative colitis as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with ulcerative colitis, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#).**
6. Refer to a mental health agency or provider.

UC-C COMPLICATIONS

OUTCOME: The patient/family will understand the signs of complications of ulcerative colitis.

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.

UC-CM CASE MANAGEMENT

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

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.”](#)**

UC-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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 and is characterized by remission and exacerbations. 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. Symptoms may include fatigue, weight loss, anorexia, nausea, vomiting, loss of body fluids and nutrients, and abdominal pain.
5. 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding ulcerative colitis.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding ulcerative colitis and dealing with issues.
2. Provide the help line phone number or Internet address (URL), such as <http://digestive.niddk.nih.gov/ddiseases/pubs/colitis/>

UC-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy
 - b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.

UC-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to ulcerative colitis.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.

2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Discuss colostomy care, if appropriate. **Refer to [“OST - Ostomy](#).**
4. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

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-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for ulcerative colitis.

STANDARDS:

1. Discuss lifestyle adaptations specific to ulcerative colitis. Discuss adaptations specific to colostomy, if appropriate.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.

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.

UC-MNT MEDICAL NUTRITION THERAPY

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

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 the role of nutrition in controlling ulcerative colitis.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
3. Explain that bland, soft foods may cause less discomfort than spicy or high fiber foods when the disease is active. Assist the patient/family in developing an appropriate meal plan. Encourage having frequent, small meals, and chewing food thoroughly.
4. Explain the need for adequate fluid intake due to chronic diarrhea. Advise the patient to avoid cold or carbonated foods or drinks that increase intestinal motility.

5. Emphasize that proper nutrition is especially important because nutrients can be lost through dehydration. Explain that supplementation with vitamins and minerals may be necessary.
6. Refer to a Registered Dietitian (RD) as appropriate.

UC-P PREVENTION

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

STANDARDS:

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

UC-PM PAIN MANAGEMENT

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

STANDARDS:

1. 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting. Explain that short term use of narcotics may be helpful in acute pain management.
4. Explain non-pharmacologic measures that may be helpful with pain control.
5. Instruct the patient in careful cleansing and protection of the perianal skin to provide comfort and prevent painful excoriation.
6. Advise the patient not to use over-the-counter pain medications without checking with the patient’s provider.

UC-PRO PROCEDURE

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 of 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 for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

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 and can interfere with the treatment of ulcerative colitis.
2. Explain that effective stress management may reduce the number of relapses, 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 from ulcerative colitis.
4. Explain that fear of eating is a common stress response in ulcerative colitis and inappropriate eating will exacerbate the symptoms of ulcerative colitis. **Refer to ["UC-N Nutrition"](#).**
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.

UC-TE TESTS

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

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results
3. Discuss 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.

4. Discuss 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.
5. Discuss 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.
6. Explain that if the procedure/test involves sedation, the patient will have to bring a driver.

UC-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.
5. 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. IV fluid replacement to correct dehydration.
 - b. Clear liquid diet, or in severe cases, parenteral hyperalimentation to rest the intestinal tract and restore nitrogen balance.
 - c. Treatment with medication to control inflammation and help reduce diarrhea, bleeding, and pain.
 - d. Colectomy.
6. Discuss the risk/benefit ratio and alternatives to treatment as well as the risk of non-treatment.

URI - Upper Respiratory Track Infection

URI-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

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

URI-C COMPLICATIONS

OUTCOME: The patient/family will understand

STANDARDS:

1. Discuss common complications of upper respiratory infection.
2. Describe the signs/symptoms of common complications of upper respiratory infection.

URI-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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 factors that increase the risk for acquiring an upper respiratory infection, e.g., direct physical contact, children in school.
3. Discuss signs and symptoms of an upper respiratory infection, e.g., malaise, rhinorrhea, sneezing, scratchy throat.
4. 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to upper respiratory infection.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

URI-L LITERATURE

OUTCOME: The patient/family will receive literature about upper respiratory infection.

STANDARDS:

1. Provide the 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. 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
6. 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-P PREVENTION

OUTCOME: The patient/family will understand 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.

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-C COMPLICATIONS

OUTCOME: The patient/family will understand

STANDARDS:

1. Discuss common complications of UTI.
2. Describe the signs/symptoms of common complications of and indications that medical attention should be sought.

UTI-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

UTI-DP DISEASE PROCESS

OUTCOME: The patient/family will understand 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. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding UTI.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding UTI and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

UTI-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of UTI.

STANDARDS:

1. Explain the home management techniques.

2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

UTI-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

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 feminine 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. Review the aspects of good personal male hygiene as it relates to prevention of UTIs. Discuss the role of foreskin hygiene as appropriate.
3. Discuss the importance of hand-hygiene in infection prevention.

- a. Explain the importance especially during food preparation and eating, diaper changing, toilet use, and wound management.
- b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
- c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
4. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

UTI-L LITERATURE

OUTCOME: The patient/family will receive literature about urinary tract infections.

STANDARDS:

1. Provide the 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.
 - b. Discuss the importance of completing the entire medication regimen (and not stopping when symptoms improve) to avoid development of drug-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

UTI-MNT MEDICAL NUTRITION THERAPY

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

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. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake. Decrease consumption of colas and caffeinated beverages.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

UTI-P PREVENTION

OUTCOME: The patient/family will understand prevention strategies for UTI.

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.
5. If the patient has an indwelling urinary catheter, explain that indwelling catheters predispose the patient to a UTI. Explain that the longer the catheter is in place, the greater the chance of a UTI.

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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

UTI-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent

- b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

UTI-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s), e.g., NPO, have a full bladder, void prior to test
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

UTI-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 participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

UCATH - Urinary Catheter and Associated Infection

UCATH-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to the urinary tract and indwelling urinary catheter.

STANDARDS:

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

UCATH-C COMPLICATIONS

OUTCOME: The patient/family will understand common and important complications of having an indwelling urinary catheter.

STANDARDS:

1. Discuss common complications of having an indwelling urinary catheter, particularly catheter-associated urinary tract infections (CAUTI).
2. Describe the signs/symptoms of common complications and methods of prevention.

UCATH-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the conditions requiring an indwelling urinary catheter and conditions leading to catheter-associated urinary tract infection (CAUTI).

STANDARDS:

1. Discuss the risks associated with having an indwelling urinary catheter, which can include urethral trauma, bleeding, infection (CAUTI).
2. Explain how a CAUTI develops.

UCATH-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment

**PATIENT EDUCATION PROTOCOLS:
URINARY CATHETER AND ASSOCIATED INFECTION**

- b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies
 - g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care, and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.

UCATH-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up regarding the use of an indwelling urinary catheter.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

UCATH-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of an indwelling urinary catheter.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

UCATH-HY HYGIENE

OUTCOME: The patient/family will understand personal routine hygiene as it relates to the indwelling urinary catheter.

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STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand hygiene after handling the urinary catheter or drainage.
 - b. Explain this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request hospital or clinic staff members to wash their hands if the staff member does not do so in plain sight.
2. Explain the importance of proper care of the closed urinary drainage system.
 - a. keeping the drainage system continuously connected
 - b. regular emptying of the drainage system before it is overfull
 - c. keeping the drainage spout clean and emptying the drainage system into a clean container
3. Review the importance of daily bathing, paying special attention to the genital area around the urinary meatus. Emphasize that the inpatient should ask for this care if it has not been provided.

UCATH-L LITERATURE

OUTCOME: The patient/family will receive literature regarding indwelling urinary catheters and/or catheter-associated urinary tract infection (CAUTI).

STANDARDS:

1. Provide the patient/family with literature regarding indwelling urinary catheters and/or catheter-associated urinary tract infection (CAUTI). **Refer to [“UTI- Urinary Tract Infection.”](#)**
2. Discuss the content of the literature.

UCATH-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for maintaining an indwelling urinary catheter after discharge.

STANDARDS:

1. Discuss lifestyle adaptations specific to an indwelling urinary catheter after discharge.
2. Discuss that the family may also require lifestyle adaptations to care for the patient.
3. Discuss ways to optimize quality of life.
4. Refer to community services, resources, or support groups, as available.

**PATIENT EDUCATION PROTOCOLS:
URINARY CATHETER AND ASSOCIATED INFECTION**

UCATH-M MEDICATIONS

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

STANDARDS:

1. Describe the name and purpose 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

UCATH-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce the risk of developing a catheter-associated urinary tract infection (CAUTI).

STANDARDS:

1. Discuss that an indwelling urinary catheter predisposes to urinary tract infections and the longer the catheter is in place the greater the chance of infection.
2. Explain measures that can be taken to reduce the chance of CAUTI.
 - a. removal of the catheter as soon as possible
 - b. hand hygiene with soap and water or alcohol-based hand cleaners before and after handling the urinary catheter or drainage system
 - c. at least daily cleaning of the urinary meatus with soap and water
 - d. maintaining the drainage system by keeping:
 - i. the drainage system continuously connected to the catheter
 - ii. the catheter secured to prevent movement and urethral traction
 - iii. the drainage bag below the level of the bladder
 - iv. the drainage spout clean
 - v. the drainage container emptied into a clean container before overfull

**PATIENT EDUCATION PROTOCOLS:
URINARY CATHETER AND ASSOCIATED INFECTION**

UCATH-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient, and it may be multifaceted. **Refer to [“PM - Pain Management.”](#)**
3. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

UCATH-PRO PROCEDURE

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, as well as the alternative and the risk of non-treatment.
2. Explain the process and what is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

UCATH-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to an indwelling urinary catheter.

STANDARDS:

1. Explain that the urinary catheter tubing may cause the patient to trip.

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2. Emphasize the importance for inpatients to call for help before ambulating.
3. Discuss ways to handle the tubing to prevent a safety issue.

UCATH-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

UCATH-TX TREATMENT

OUTCOME: The patient/family will understand the treatment plan as it relates to indwelling urinary catheter and the catheter-associated urinary tract infection (CAUTI).

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

V

VENT - Ventilation (Mechanical) and Associated Pneumonia

VENT-ADV ADVANCE DIRECTIVE

OUTCOME: The patient/family 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 many persons are not able to make their own decisions when ill. The advance directive, or other statement of care preferences, allows patients to express their preferences and guide treatment decisions in that setting.
2. Explain that this statement of preferences is only used to guide decision making if the patient is able to provide guidance at the time that decisions need to be made.
3. Explain that the Advance Directives or other statements of care preferences can help families and caregivers who may need to be decision-makers for the patient to understand the patient's preferences of care.
4. Review the option of Advanced Directives or other statements of care preferences with the patient and the patient's family. Explain treatment options and answer questions in a manner the patient/family will understand.
5. Refer as appropriate to those who can assist the patient in further clarifying healthcare decision-making authority (e.g., Social Services, Clergy, Lawyer) by defining a healthcare proxy, writing a living will, or further discussing the preferences for care.

VENT-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand anatomy and physiology as it relates to the respiratory system and the use of a mechanical ventilator.

STANDARDS:

1. Explain the normal anatomy and physiology of the respiratory system.
2. Discuss changes to anatomy and physiology as a result of the use of an endotracheal tube or tracheostomy and mechanical ventilator.
3. Discuss the impact of these changes on the patient's health or well-being, including the inability to eat or speak while intubated.

**PATIENT EDUCATION PROTOCOLS:
VENTILATION (MECHANICAL) AND ASSOCIATED PNEUMONIA**

VENT-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications of mechanical ventilator use.

STANDARDS:

1. Discuss common complications of ventilator use, particularly ventilator-associated pneumonia. Other complications may include pneumothorax, hypotension, airway injury, alveolar damage.
2. Describe the signs/symptoms of common complications of ventilator-associated pneumonia.
3. Describe the signs/symptoms of other common complications of mechanical ventilator use.
4. Explain the intense monitoring and care that is provided to prevent complications and identify them if they occur.

VENT-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the condition(s) that led to the need for mechanical ventilation or ventilator-associated pneumonia (VAP).

STANDARDS:

1. Explain that a VAP is an infection in the lung(s) related to having an artificial airway and mechanical ventilation.
2. Discuss the risks associated with requiring mechanical ventilation, including VAP.
3. Explain how a VAP develops and some measures that will be taken to prevent it.

VENT-EQ EQUIPMENT

OUTCOME: The patient/family will understand the basic use of the mechanical ventilator.

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. indication for the equipment
 - b. benefits of using the equipment
 - c. types and features of the equipment
 - d. proper function of the equipment
 - e. signs of equipment malfunction and proper action in case of malfunction
 - f. infection control principles, including proper disposal of associated medical supplies

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- g. importance of not tampering with any medical device
2. Explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.

VENT-EX EXERCISE

OUTCOME: The patient/family will understand the role of active or passive physical therapy and early ambulation, as appropriate, in maintaining the patient's strength and flexibility.

STANDARDS:

1. Discuss medical clearance issues for physical activity.
2. Discuss the appropriate frequency, intensity, time, and type of activity and how the patient and others may be of assistance.

VENT-HY HYGIENE

OUTCOME: The patient/family will understand hygiene as it relates to the use of mechanical ventilation.

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of frequent oral hygiene with an antimicrobial agent and oral suction to remove accumulated secretions in the prevention of VAP.
3. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
4. Review the risks of exposing immunocompromised critically ill patients to communicable diseases.

VENT-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 that the patient must be intubated with an endotracheal tube or tracheostomy tube in order to receive mechanical ventilation.

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2. Explain the basic procedure for endotracheal intubation, including the risks and benefits of endotracheal intubation and the adverse events which might result from refusal.
3. Discuss alternatives to endotracheal intubation, including expectant management, as appropriate.
4. Explain that the patient will be sedated and unable to speak or eat while intubated.
5. Discuss the potential necessity for using physical restraint to maintain intubation while the patient is heavily sedated and requiring mechanical ventilation.
6. Explain that the patient will be extubated as soon as it is medically feasible.

VENT-L LITERATURE

OUTCOME: The patient/family will receive literature regarding the use of mechanical ventilation and ventilator-associated pneumonia (VAP).

STANDARDS:

1. Provide the patient/family with literature regarding mechanical ventilation.
2. Discuss the content of the literature.

VENT-M MEDICATIONS

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

STANDARDS:

1. Describe the name and purpose of the medication.
2. Explain the modality utilized to administer the various medications to the patient requiring mechanical ventilation, e.g. nebulizers, metered dose inhalers, nasogastric tube, or intravenous.
3. Discuss the risks, benefits, and common or important side effects of the medication and follow up as appropriate.

VENT-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed while mechanical ventilation is required.

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

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- 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.

VENT-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to mechanical ventilation.

STANDARDS:

1. Emphasize the importance of nutrition to healing, even while the patient cannot take nutrition orally.
2. Emphasize that nutritional management for a patient requiring mechanical ventilation may include feeding by nasogastric tube or by hyperalimentation via an IV catheter or central line.
3. Refer to registered dietitian for MNT.

VENT-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of developing ventilator-associated pneumonia (VAP) and other complications.

STANDARDS:

1. Explain that there are three types of interventions, physical, positional and pharmacologic, to prevent VAP.
 - a. Physical interventions may include:
 - i. using frequent circuit and humidifier changes
 - ii. using closed suction and ventilator tubing systems and replacing them as recommended by current standards
 - b. Positional interventions may include keeping the patient's head elevated at least 30°.
 - c. Pharmacologic interventions may include:
 - i. using regular and frequent oral care with an antiseptic agent
 - ii. using antibiotics or anti-reflux medications

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2. Discuss ways to reduce the change of VAP, including:
 - a. taking the patient off the ventilator as soon as the patient can breathe on own
 - b. using careful and regular hand hygiene for staff and visitors

VENT-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that the patient's pain and level of anxiety will be monitored closely.
2. Explain that adequate medication will be administered to maintain the patient's comfort, including the anxiety that frequently accompanies mechanical ventilation.
3. 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.
4. Explain that pain management is specific to the disease process and the patient, and it may be multifaceted. **Refer to ["PM - Pain Management."](#)**
5. Explain that medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
6. Explain non-pharmacologic measures that may be helpful with pain control.

VENT-PRO PROCEDURE

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 of 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 for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

**PATIENT EDUCATION PROTOCOLS:
VENTILATION (MECHANICAL) AND ASSOCIATED PNEUMONIA**

VENT-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to mechanical ventilation.

STANDARDS:

1. Explain that mechanical ventilation is a life support modality.
2. Explain that there are numerous alarms associated with the ventilator that notify staff when there is an issue with the equipment or the patient. Explain that some of these are routine notification alarms and some require immediate action.
3. Reassure the patient/family that the staff are trained and competent to handle these issues.
4. Discuss the potential necessity for using physical restraint to maintain intubation while the patient is heavily sedated and requiring mechanical ventilation.
5. Explain the intense monitoring and care that is provided for safety, to prevent complications and identify them if they occur.

VENT-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

**PATIENT EDUCATION PROTOCOLS:
VENTILATION (MECHANICAL) AND ASSOCIATED PNEUMONIA**

VENT-TX TREATMENT

OUTCOME: The patient/family will understand the treatment plan for mechanical ventilation and ventilator-associated pneumonia (VAP).

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

VENT-VAP VENTILATOR-ASSOCIATED PNEUMONIA

OUTCOME: The patient/family will have a basic understanding of ventilator-associated pneumonia (VAP).

STANDARDS:

1. Explain the possible causes of VAP.
2. Explain the plan for preventing VAP.
3. Explain the plan for treating VAP.

W

WNV - West Nile Virus

WNV-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of West Nile Virus.

STANDARDS:

1. Explain that few people who contract WNV develop serious infections. People over 50 years of age are at highest risk for serious infections, which may lead to death.
2. Discuss symptoms develop between 3 and 14 days after an infected mosquito bite. The symptoms may last several weeks, and neurological effects may be permanent:
 - a. Mild symptoms include: fever, headache, and body aches, nausea, vomiting, swollen lymph glands, or a skin rash.
 - b. Serious symptoms include: high fever, headache, neck stiffness, stupor, disorientation, coma, tremors, convulsions, muscle weakness, vision loss, numbness, and paralysis.

WNV-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the West Nile Virus (WNV).

STANDARDS:

1. Discuss that WNV is a potentially serious illness spread through infected mosquitoes, blood transfusions, and perinatally. WNV is more common in the summer through the fall.
2. Explain that most people infected with WNV will not show any symptoms. Some people will have mild symptoms and few people develop serious symptoms.
3. Discuss that symptoms develop between 3 and 14 days after an infected mosquito bite. The symptoms may last several weeks, and neurological effects may be permanent:
 - a. Mild symptoms include: fever, headache, and body aches, nausea, vomiting, swollen lymph glands, or a skin rash.
 - b. Serious symptoms include: high fever, headache, neck stiffness, stupor, disorientation, coma, tremors, convulsions, muscle weakness, vision loss, numbness, and paralysis.

WNV-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
 - a. Indication for the equipment
 - b. Benefits of using the equipment
 - c. Types and features of the equipment
 - d. Proper function of the equipment
 - e. Signs of equipment malfunction and proper action in case of malfunction
 - f. Infection control principles, including proper disposal of associated medical supplies
 - g. The importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

WNV-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of West Nile Virus (WNV).

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

WNV-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Review the community resources available for prevention of WNV.

2. Explain that dead birds should not be handled with bare hands. Contact your local health department for instructions on reporting and disposing of the dead bird.
3. Discuss wellness as an individual responsibility to:
 - a. Learn how to be healthy.
 - b. Be willing to change.
 - c. Set small, realistic, sustainable goals.
 - d. Practice new knowledge.
 - e. Get help when necessary.

WNV-L LITERATURE

OUTCOME: The patient/family will receive literature about West Nile Virus (WNV).

STANDARDS:

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

WNV-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for West Nile Virus (WNV).

STANDARDS:

1. Discuss lifestyle adaptations specific to WNV. This involves prevention techniques such as limiting time outside during dusk and dawn, wearing of long sleeve clothing and/or repellents and lawn maintenance.
2. Discuss lifestyle adaptations necessary to cope with permanent disability as a result of WNV.
3. Refer to community services, resources, or support groups, as available.

WNV-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

WNV-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed for West Nile Virus (WNV).

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.

WNV-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to West Nile Virus (WNV).

STANDARDS:

1. Discuss the need for adequate fluid intake if symptoms include nausea, vomiting or diarrhea.
2. Refer to registered dietitian for MNT or other local resources as appropriate.

WNV-P PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of contracting West Nile Virus (WNV).

STANDARDS:

1. Discuss ways of preventing mosquito bites.
 - a. When outdoors use insect repellent.
 - b. Wear long sleeves and pants.
 - c. Utilize screens in windows and doors.
 - d. Reduce outdoor time during dusk and dawn (highest mosquito activity).
 - e. Remove breeding sites by draining standing water (flower pots, buckets, tires, barrels). Change pet dishes and bird baths regularly. Keep other items on their sides while not in use.
2. Explain that dead birds should not be handled with bare hands. Instruct family members, especially children, not to handle dead birds. Contact your local health department for instructions on reporting and disposing of the dead bird.

WNV-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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

WNV-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

WNV-TX TREATMENT

OUTCOME: The patient/family will understand the treatment plan for West Nile Virus (WNV).

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation in the treatment plan.
2. Discuss that milder case of WNV require no specific treatment – fever and aches usually subside on their own.
3. Discuss that more severe cases may require hospitalization for supportive care, including IV fluids, help with breathing, and nursing care.
4. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.

WH - Women's Health

WH-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand 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. Discuss the normal changes that occur with pregnancy and lactation, menstruation, and aging.
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 benefits, limitations, and potential harms associated with breast self-examination.

STANDARDS:

1. Discuss that controversy exists over screening recommendations for breast exams by self and clinician. Recommendations are different for low-risk vs. high-risk patients.
2. Discuss that potential benefits of breast exam may include early detection and treatment of breast cancer. The evidence for this is inconclusive.
3. Discuss the limitations of breast exams due to normal physiological changes that occur with pregnancy, breast feeding, menstruation, and age. These changes can make detection difficult and lead to false positives and false negatives.
4. If agreed upon by provider and patient, teach breast self-examination. Have the patient give a return demonstration. Discuss normal findings, fibrocystic breast changes, and warning signs to watch for with breast self-examination.
5. Discuss that clinical breast exam (CBE) performed by a qualified healthcare professional may be considered in some patient cases. CBE is of potential benefit when mammography is not indicated or not available.
6. Discuss there may be harms from screening including psychological harms, additional medical visits, imaging and biopsies in women without cancer, inconvenience due to false positive screenings, and harms of unnecessary treatment.

WH-BH BEHAVIORAL AND EMOTIONAL HEALTH

OUTCOME: The patient/family will understand the behavioral, emotional, and psychological components surrounding women's health issues such as multiple births, bereavement, depression, and self esteem issues.

STANDARDS:

1. Discuss the common difficulty in coping with the initial impact of being diagnosed with acute or chronic illness as a life-altering illness that requires a change in lifestyle.
2. Discuss the potential stress, anger, sadness, fear, and/or other emotional reactions that are common in being diagnosed with acute or chronic health problems, and the danger of further complications or mental health diagnoses related to untreated emotional turmoil.
3. Discuss that the healing process incorporates traditional medical, spiritual, mental/emotional, and cultural components.
4. Discuss the danger of denial about the diagnosis, and the importance of seeking help in accepting and coping with the illness.
5. Discuss the potential of dangers of self-medication of emotional disturbance with tobacco, alcohol, or other drugs. **Refer to [“AOD - Alcohol and Other Drugs”](#).**
6. Refer to a mental health agency or provider.

WH-CRC COLORECTAL CANCER SCREENING

OUTCOME: The patient/family will understand the importance of colorectal cancer screening as it relates to maintaining optimal health.

STANDARDS:

1. Explain that screening for colorectal cancer should begin at age 50 or sooner if there is a family history of cancer. Explain that diagnosing cancer at the earliest stage often provides the best chance for a cure.
2. Discuss the following risk factors: older age, African American race, personal history of colorectal cancer or polyps, history of ulcerative colitis or Crohn's disease, genetic syndromes, family history of colon cancer or colon polyps, low-fiber and high fat diet, sedentary lifestyle, diabetes, obesity, smoking, heavy alcohol use, radiation therapy for previous cancers.
3. Discuss environmental factors that may contribute to the development of colorectal cancer such as asbestos, benzene, and cigarette smoke.
4. Discuss available techniques and recommended intervals for screening for colorectal cancer, as appropriate. Discuss necessary pre-test preparation including foods to avoid, medications to stop or start, bowel preparation, and testing procedure.

- a. Fecal Occult Blood Testing
 - b. Sigmoidoscopy
 - c. Colonoscopy
5. Discuss the importance of follow-up for results, and further testing if needed for definitive diagnosis.

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. 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 no 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. Explain the risks, benefits, alternative, and results of non-treatment. Emphasize that the outlook is good with early diagnosis and treatment.
4. Review self-care following cryotherapy and the restrictions regarding sexual activity, tampons, and douching.
5. Reinforce the need to keep follow-up appointments and check-ups, as recommended by the provider. Explain that follow-up pap smears are often recommended to verify success of treatment and to detect any recurrence of abnormal cells.

WH-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

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-FP FAMILY PLANNING (REFER TO FP)**WH-FU FOLLOW-UP**

OUTCOME: The patient/family will understand the importance of follow-up for women's health.

STANDARDS:

1. Emphasize the importance of follow-up care. Discuss patient specific recommendations for well woman care, including breast exams, pap smears, and STI checks according to current guidelines.
2. Discuss the procedure and process for obtaining follow-up appointments.
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-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding women's health.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding women's health and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

WH-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to the whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
3. Discuss wellness as an individual responsibility to:
 - a. learn how to be healthy

- b. be willing to change
 - c. set small, realistic, sustainable goals
 - d. practice new knowledge
 - e. get help when necessary
4. Review the community resources available for help in achieving behavior changes.
 5. Review common causes of death and disability in women including cardiovascular disease, cancer, lung disease, diabetes, infection, and ways to reduce these risks.

WH-HY HYGIENE

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

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
 - a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
 - b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
 - c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

WH-IM IMMUNIZATIONS

OUTCOME: The patient will understand the immunizations necessary for preventing communicable diseases. **Refer to ["IM - Immunizations"](#).**

STANDARDS:

1. Discuss the schedule for recommended immunizations and illnesses they prevent. Review when the following immunizations would be used, as appropriate:
 - a. Tetanus
 - b. Pneumonia

- c. Influenza
 - d. MMR (measles, mumps, rubella)
 - e. HPR (for certain types of cervical cancer)
 - f. Hepatitis A and B
 - g. Meningococcal
 - h. Zoster (shingles)
2. Discuss the side effects and potential adverse reactions that are common to this immunization.
 3. Discuss the potential consequences of vaccine refusal.
 4. Discuss the treatment of side effects and home care after immunizations.

WH-KE KEGEL EXERCISES

OUTCOME: The patient will understand how to use Kegel exercises to manage 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 the risks and benefits of treatment, alternative treatment, and results of non-treatment.
3. Discuss patient preparation and positioning for the procedure.
4. Review self-care following LEEP, e.g., bleeding, cramping, pain, and any restrictions regarding sexual intercourse, daily activity, douching, use of tampons, tub baths.
5. 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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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.

WH-MAM MAMMOGRAM

OUTCOME: The patient/family will understand the role of mammograms in patient specific situations.

STANDARDS:

1. Discuss that controversy exists over screening recommendations for mammograms. Recommendations are different for low-risk vs. high-risk patients.
2. Discuss the current recommendations for screening mammograms. Women at higher risk may require earlier or more frequent mammogram screenings.
3. Discuss the benefits, limitations, and potential harms associated with regular mammogram screenings.

4. Explain the process of having a mammogram, necessary preparations, the time to expect a report, and the recommended follow up.
5. Explain the indications for further medical testing including diagnostic mammography.

WH-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient/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 - Menopause"](#).**
2. Explain that menopause begins naturally when the ovaries start making less estrogen and progesterone. Menopause can also result from surgery. 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. **Refer to ["FP - Family Planning"](#).**

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.
5. Review using 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.
5. Discuss the non-contraceptive use of oral contraceptives to regulate menses.

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 consumption of sodium, colas, coffee, and alcohol
 - c. drink WATER
 - d. add more fresh fruits, vegetables, and fiber
 - e. get adequate intake of calcium and vitamin D (refer to [“WH-OS Osteoporosis”](#))
 - f. get adequate folic acid intake
 - g. avoid carbonated beverages to retain bone health
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. Discuss folic acid supplementation during child bearing years.

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. **Refer to [“OS - Osteoporosis”](#).**
2. Explain that 90% of peak bone mass is acquired by age 18 and that without intervention, progressive bone loss is typical. The manifestations of bone loss include:
 - a. stooped shoulders
 - b. loss of height
 - c. back, neck, and hip pain
 - d. susceptibility to fractures
3. Review the risk factors:
 - a. low dietary intake of calcium, vitamin D
 - b. sedentary lifestyle
 - c. high intake of carbonated beverages
 - d. familial history
 - e. smoking
 - f. stress
 - g. age over 40
 - h. female gender
 - i. race
 - j. small stature
 - k. 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, reduced carbonated beverage intake, and estrogen replacement as appropriate. **Refer to [“OS-P Prevention”](#).**

WH-PAP PAP SMEAR / PELVIC EXAM

OUTCOME: The patient will understand the importance of routine pap testing.

STANDARDS:

1. Explain that the purpose of the pap test is to screen for precancerous conditions that are highly treatable.
2. 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.
3. If this is the patient's first pap test, explain the procedure including positioning, placement of speculum, collection of cells, bimanual exam.
4. Explain the reason(s) for the test and the follow-up recommended. Discuss the results of the test as appropriate. Discuss the procedure for obtaining the results of the pap test.
5. Explain that pelvic exams without a pap test may be used to screen for STIs and other infections.

WH-PCC PRE-CONCEPTION CARE

OUTCOME: The patient/family will understand the importance of pre-conception care health and planning.

STANDARDS:

1. Explain that adequate intake of nutrients is beneficial to women of child bearing age.
 - a. Folic acid - decrease risk of neural tube defects
 - b. Calcium and vitamin D - promote bone health
2. Discuss that a healthy weight at conception can reduce birth defects. Refer to dietitian as appropriate.
3. Discuss the importance of blood sugar normalization during preconception and pregnancy in preventing birth defects.
4. Discuss the importance of avoiding of tobacco, alcohol, and other drugs. Discuss the need to review all medications and herbal products with a provider or pharmacist.
5. Discuss the importance of advanced family planning (reproductive planning). Discuss planning issues such as:
 - a. financial status
 - b. maternal age
 - c. lifestyle changes
 - d. employment
 - e. number and spacing of pregnancies

- f. childcare
- 6. Refer for medical and psychosocial support services for any risk factor identified.

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.

WH-PRO PROCEDURE

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 indication, risks, and 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 necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. informed consent
 - b. patient identification
 - c. marking the surgical site
 - d. time out for patient identification and procedure review
 - e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

WH-S SAFETY

OUTCOME: The patient/family will understand safety as it relates to domestic violence. Refer to ["DVV - Domestic Violence - Victim"](#).

STANDARDS:

1. Discuss the availability of shelters and other support options in their area. Offer a list of resources and make referrals as appropriate.
2. Assist in developing a plan of action that will ensure safety of all people in the environment of violence.
3. Explain the need for the family to develop a specific plan if and when the victim decides to leave the home.

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 worsen 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 STI)**WH-SX SEXUALITY**

OUTCOME: The patient will understand the important aspects of sexuality.

STANDARDS:

1. Discuss that the decision to have sex is an individual decision. Peer pressure to have sex can be intense. The decision to have sex should always be discussed between partners.
2. Discuss healthy sexual behavior:
 - a. monogamous relationships
 - b. consensual sex
 - c. open and honest conversations with partner about sexual likes and dislikes
 - d. family planning and use of effective birth control
3. Explain sexual terms such as orgasm, foreplay, ejaculation, or any other terms unfamiliar to patient. Also explain what to expect during intercourse and symptoms that should be reported to a healthcare provider.
4. Discuss the importance of making a reproductive plan and pre-conception care when applicable.
5. Explain that promiscuous sexual behavior substantially increases the risk of sexually transmitted infections. These infections can lead to ectopic pregnancy, infertility, systemic infections, or chronic pelvic pain. Also emphasize that HIV, hepatitis, and herpes can be sexually transmitted and have no cures.
6. Emphasize that abuse, (i.e., sexual, emotional, or physical) should not be tolerated. Emphasize the importance of reporting domestic violence to the proper law enforcement and child welfare/protective agencies and the patient's healthcare provider. Discuss the availability of shelters and other support options in the area. Offer a list of resources and make referrals as appropriate. **Refer to ["DVV-IR Information and Referral"](#).**

WH-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed

- c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
- a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

Y**YEAST - Yeast Infection****YEAST-AP ANATOMY AND PHYSIOLOGY**

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

STANDARDS:

1. Explain the normal anatomy and physiology of the affected area (usually skin, mouth and throat, or reproductive organs).
2. Discuss the changes to anatomy and physiology as a result of yeast infections.
3. Discuss the impact of these changes on the patient's health or well-being.

YEAST-C COMPLICATIONS

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

STANDARDS:

1. Explain that repeated yeast infections may be a sign of a more serious condition.
2. Describe the common complications of yeast infections:
 - a. Vaginal yeast infections can lead to chronic discharge, itching, pain with urination, pain with intercourse.
 - b. Oral or pharyngeal yeast infections can lead to weight loss, malnutrition, or dehydration.
 - c. Skin yeast infections cause increased susceptibility to bacterial infections, which may become threatening to life or limb.
 - d. Widespread (disseminated) candidiasis may occur in immunocompromised individuals.
3. Explain that devices such as urinary catheters and IV ports provide access for the yeast to enter the body. Persons who are IV drug addicts who use dirty needles may inject yeast directly into their blood stream or deep tissues.

YEAST-CM CASE MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of integrated case management in managing the impact of yeast infections.

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”](#).**

YEAST-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 health and wellness.

STANDARDS:

1. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness. Refer to clergy services, traditional healers, or other culturally appropriate resources.
2. Explain that traditional medicines/treatments should be reviewed with the healthcare provider to determine if there are potential interactions with prescribed treatment. Explain that the medical treatment plan must be followed as prescribed to be effective.

YEAST-DP DISEASE PROCESS

OUTCOME: The patient/family will understand that candidiasis (yeast infections) is caused by a group of microscopic fungi or yeast.

STANDARDS:

1. Discuss the signs/symptoms of yeast infections.
2. Explain that yeast infections are caused by a fungus. *Candida albicans* is the most common cause of genital and oral infections.
3. Explain predisposing factors to yeast infections as appropriate:
 - a. Treatment with antibiotics that kill bacteria that otherwise control fungal growth
 - b. Moisture retention on the skin, e.g., people who frequently have their hands in water, children who suck a thumb, babies who stay in wet diapers, skin folds of the obese
 - c. Uncontrolled diabetes
 - d. Impaired immune response
 - e. Use of spermicidal jellies or creams

- f. Ill-fitting dentures
4. Discuss that women should see a healthcare provider the first time they suspect a yeast infection. Occasionally yeast infections are mistaken for other similar vaginal infections such as bacterial vaginosis or allergic reactions. Recurrent or uncleared infections should be evaluated by a medical provider.

YEAST-EX EXERCISE

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

STANDARDS:

1. Discuss that vigorous exercise produces more sweat, which means warmer, moist dark places for Candida yeast to thrive. Avoid wearing tight workout clothes and nylon underwear (that traps heat). Remove sweaty clothes and wet swim suits ASAP.
2. Discuss medical clearance issues for new physical activity. Current exercise can be maintained.
3. Discuss the benefits of any physical activity, such as improvement in well being, stress reduction, sleep, bowel regulation, and improved self image.
4. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
5. Discuss the appropriate frequency, intensity, time, and type of activity.
6. Refer to community resources as appropriate.

YEAST-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.
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.

YEAST-HELP HELP LINE

OUTCOME: The patient/family will understand how to access and benefit from a help line or Internet website regarding yeast infections.

STANDARDS:

1. Explain that support groups and reliable information may assist in answering questions regarding yeast infections and dealing with issues.
2. Provide the help line phone number or Internet address (URL).

YEAST-HPDP HEALTH PROMOTION, DISEASE PREVENTION

OUTCOME: The patient/family will understand the lifestyle changes necessary to promote and sustain healthy living.

STANDARDS:

1. Explain that health and wellness refers to whole person (mind, body, and spirit) and is a positive state which results from healthy choices.
2. Explain healthy lifestyle choices (e.g., spirituality, social connections, exercise, nutrition) and avoidance of high risk behaviors (e.g., smoking, alcohol and substance abuse, sex with multiple partners). Discuss the benefits of a healthy lifestyle.
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.

YEAST-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of yeast infections.

STANDARDS:

1. Explain the home management techniques. If certain that the infection is a yeast condition, it can be treated with over-the-counter medications.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, as appropriate.

YEAST-HY HYGIENE

OUTCOME: The patient will recognize good personal hygiene as it relates to yeast infections.

STANDARDS:

1. Review the importance of bathing, paying special attention to face, pubic hair area, skin folds, diaper areas, and feet. Discuss hygiene as part of a positive self image.
2. Review the importance of daily dental hygiene (thrush), with attention to brushing and flossing. Remind patients who use inhaled steroids to rinse the mouth after each use.
3. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

YEAST-L LITERATURE

OUTCOME: The patient/family will receive literature about yeast infections.

STANDARDS:

1. Provide the patient/family literature on yeast infections.
2. Discuss the content of the literature.

YEAST-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 full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
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. Stress the importance of choosing over-the-counter treatments indicated for the specific site of infection.

YEAST-N NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to yeast infection.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the importance of regular meals and adequate fluid intake. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
4. Refer to registered dietitian for MNT or other local resources as appropriate.

YEAST-P PREVENTION

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

STANDARDS:

1. Explain that keeping skin clean and dry is a major deterrent to the growth of yeast on the skin.
2. Explain that control of blood glucose for diabetics helps prevent yeast infections, as appropriate.
3. Discuss the use of live-culture yogurt or pro-biotics. **Refer to [“YEAST-N Nutrition”](#)**.
4. Avoid wearing tight workout clothes and nylon underwear (which traps heat). Remove sweaty clothes and wet swim suits ASAP.
5. Discuss methods to prevent reinfection or transmission.
 - a. To prevent vaginal infections, wear cotton underwear and avoid douches.
 - b. To prevent skin infections, keep the area clean and dry.
 - c. For infants with oral thrush, discuss that all bottle nipples and pacifiers should be washed in hot, soapy water. If the infant is breast-fed, the mother is likely to be treated as well.

YEAST-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand and fully participate in 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 and the patient; and may be multifaceted. **Refer to [“PM - Pain Management”](#).**
3. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain, such as nausea and vomiting.
4. Explain non-pharmacologic measures that may be helpful with pain control.

YEAST-PRO PROCEDURE

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, 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 is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
 - a. Informed consent
 - b. Patient identification
 - c. Marking the surgical site
 - d. Time out for patient identification and procedure review
 - e. Measures to prevent surgical site infections
5. Discuss pain management as appropriate.

YEAST-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that unmanaged stress can have an adverse effect.
2. Explain the role of effective stress management in yeast infection.
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.

YEAST-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
 - a. method of testing
 - b. necessity, benefits, and risks of test(s) to be performed
 - c. any potential risk of refusal of recommended test(s)
 - d. any advance preparation and instructions required for the test(s)
 - e. how the results will be used for future medical decision-making
 - f. how to obtain the results of the test
2. Explain test results:
 - a. meaning of the test results
 - b. follow-up tests may be ordered based on the results
 - c. how results will impact or effect the treatment plan
 - d. recommendations based on the test results

YEAST-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 participation in the treatment plan.
2. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
3. Explain that compliance with the treatment plan is essential. Explain that treatment of yeast infections varies according to the site, severity and organism causing the yeast infection. Treatment is usually topical but can be oral or IV.

YEAST-WC WOUND CARE

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

STANDARDS:

1. Explain the reasons to care appropriately for the wound, e.g., decreased infection rate, improved healing.
2. Emphasize the importance of hand hygiene before and after caring for the wound and the relationship to preventing infection. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
3. Explain the correct procedure for caring for this patient's wound, including the use of personal protective equipment. As appropriate the patient/family will demonstrate the necessary wound care techniques.
4. Detail the supplies necessary for care of this wound (if any) and how/where they might be obtained. Emphasize the proper methods for disposal of used supplies.
5. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
6. Discuss any special recommendations or instructions particular to the patient's wound.

Index of Codes

ABD ABDOMINAL PAIN

ABD-C	Complications
ABD-DP	Disease Process
ABD-FU	Follow-up
ABD-L	Literature
ABD-M	Medications
ABD-MNT	Medical Nutrition Therapy
ABD-N	Nutrition
ABD-PM	Pain Management
ABD-SM	Stress Management
ABD-TE	Tests
ABD-TX	Treatment

ABNG ABUSE AND NEGLECT (CHILD OR ELDER)

ABNG-BH	Behavioral and Emotional Health
ABNG-CM	Case Management
ABNG-C	Complications
ABNG-CUL	Cultural/Spiritual Aspects of Health
ABNG-FU	Follow-up
ABNG-IR	Information and Referral
ABNG-L	Literature
ABNG-N	Nutrition
ABNG-P	Prevention
ABNF-PA	Parenting
ABNG-PSY	Psychotherapy
ABNG-RI	Patient Rights and Responsibilities
ABNG-RP	Mandatory Reporting
ABNG-S	Safety

ACNE ACNE

ACNE-C	Complications
ACNE-DP	Disease Process
ACNE-FU	Follow-up
ACNE-HELP	Help Line
ACNE-HY	Hygiene
ACNE-L	Literature
ACNE-M	Medications
ACNE-N	Nutrition
ACNE-TX	Treatment

ADJ ADJUSTMENT DISORDERS

ADJ-C	Complications
ADJ-CUL	Cultural/Spiritual Aspects of Health
ADJ-DP	Disease Process
ADJ-EX	Exercise
ADJ-FU	Follow-up
ADJ-HELP	Help Line
ADJ-HPDP	Health Promotion, Disease Prevention
ADJ-L	Literature
ADJ-LA	Lifestyle Adaptations
ADJ-M	Medications
ADJ-N	Nutrition
ADJ-P	Prevention
ADJ-PSY	Psychotherapy
ADJ-S	Safety
ADJ-SM	Stress Management
ADJ-TLH	Tele-Health
ADJ-TX	Treatment

AF ADMINISTRATIVE FUNCTIONS

AF-B	Benefits Of Updating Charts
AF-CON	Confidentiality
AF-FU	Follow-up
AF-IB	Insurance and Benefits
AF-ISEC	Infant Security
AF-REF	Referral Process
AF-RI	Patient Rights and Responsibilities
AF-TLH	Tele-Health

INDEX OF PATIENT EDUCATION PROTOCOLS

ADM ADMISSION TO HOSPITAL

ADM-ADV	Advance Directive
ADM-CUL	Cultural/Spiritual Aspects of Health
ADM-EQ	Equipment
ADM-HY	Hygiene
ADM-IB	Insurance and Benefits
ADM-OR	Orientation
ADM-PM	Pain Management
ADM-POC	Plan of Care
ADM-RI	Patient Rights and Responsibilities
ADM-RRT	Rapid Response Team
ADM-S	Safety

ADV ADVANCE DIRECTIVES

ADV-I	Information
ADV-L	Literature
ADV-LW	Living Will
ADV-POA	Durable Power of Attorney for Health Care
ADV-RI	Patient Rights and Responsibilities

AOD ALCOHOL AND OTHER DRUGS

AOD-AP	Anatomy and Physiology
AOD-BH	Behavioral and Emotional Health
AOD-BNI	Brief Negotiated Intervention
AOD-C	Complications
AOD-CM	Case Management
AOD-CUL	Cultural/Spiritual Aspects of Health
AOD-DP	Disease Process
AOD-EX	Exercise
AOD-FAS	Fetal Alcohol Spectrum Syndrome
AOD-FU	Follow-up
AOD-HELP	Help Line
AOD-HM	Home Management
AOD-HPDP	Health Promotion, Disease Prevention
AOD-HY	Hygiene
AOD-INJ	Injuries
AOD-IR	Information and Referral
AOD-L	Literature
AOD-LA	Lifestyle Adaptations
AOD-M	Medications
AOD-MNT	Medical Nutrition Therapy
AOD-N	Nutrition
AOD-P	Prevention
AOD-PCC	Pre-Conception Care
AOD-PSY	Psychotherapy
AOD-S	Safety
AOD-SM	Stress Management
AOD-TX	Treatment

AL ALLERGIES

AL-DP	Disease Process
AL-FU	Follow-up
AL-HELP	Help Line
AL-L	Literature
AL-LA	Lifestyle Adaptations
AL-M	Medications
AL-MNT	Medical Nutrition Therapy
AL-N	Nutrition
AL-TE	Tests

INDEX OF PATIENT EDUCATION PROTOCOLS

ALZ	ALZHEIMER'S DISEASE	AMP	AMPUTATIONS
ALZ-ADL	Activities of Daily Living	AMP-AP	Anatomy and Physiology
ALZ-ADV	Advance Directive	AMP-BH	Behavioral and Emotional Health
ALZ-AP	Anatomy and Physiology	AMP-C	Complications
ALZ-BH	Behavioral and Emotional Health	AMP-CM	Case Management
ALZ-C	Complications	AMP-CUL	Cultural/Spiritual Aspects of Health
ALZ-CM	Case Management	AMP-DP	Disease Process
ALZ-CUL	Cultural/Spiritual Aspects of Health	AMP-EQ	Equipment
ALZ-DP	Disease Process	AMP-EX	Exercise
ALZ-FU	Follow-up	AMP-FU	Follow-up
ALZ-HELP	Help Line	AMP-HPDP	Health Promotion, Disease Prevention
ALZ-HM	Home Management	AMP-L	Literature
ALZ-HPDP	Health Promotion, Disease Prevention	AMP-LA	Lifestyle Adaptations
ALZ-HY	Hygiene	AMP-M	Medications
ALZ-L	Literature	AMP-MNT	Medical Nutrition Therapy
ALZ-LA	Lifestyle Adaptations	AMP-N	Nutrition
ALZ-M	Medications	AMP-PM	Pain Management
ALZ-MNT	Medical Nutrition Therapy	AMP-S	Safety
ALZ-N	Nutrition	AMP-SM	Stress Management
ALZ-PCL	Placement	AMP-TE	Tests
ALZ-S	Safety	AMP-TX	Treatment
ALZ-SM	Stress Management	AN	ANEMIA
ALZ-TE	Tests	AN-AP	Anatomy and Physiology
ALZ-TLH	Tele-Health	AN-C	Complications
ALZ-TX	Treatment	AN-DP	Disease Process
		AN-FU	Follow-up
		AN-L	Literature
		AN-M	Medications
		AN-MNT	Medical Nutrition Therapy
		AN-N	Nutrition
		AN-PRO	Procedures
		AN-TE	Tests
		AN-TX	Treatment

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ANS	ANESTHESIA	ACC	ANTICOAGULATION
ANS-C	Complications	ACC-AP	Anatomy and Physiology
ANS-EQ	Equipment	ACC-C	Complications
ANS-FU	Follow-up	ACC-DP	Disease Process
ANS-INT	Intubation	ACC-FU	Follow-up
ANS-IS	Incentive Spirometry	ACC-HM	Home Management
ANS-L	Literature	ACC-L	Literature
ANS-PM	Pain Management	ACC-LA	Lifestyle Adaptations
ANS-PO	Postoperative	ACC-M	Medications
ANS-PR	Preoperative	ACC-MNT	Medical Nutrition Therapy
ANS-PRO	Procedures	ACC-N	Nutrition
ANS-TCB	Turn, Cough, Deep Breath	ACC-PCC	Pre-Conception Care
ABXD	ANTIBIOTIC ASSOCIATED DIARRHEA	ACC-S	Safety
ABXD-AP	Anatomy and Physiology	ACC-TE	Tests
ABXD-C	Complications	ASLT	ASSAULT, SEXUAL
ABXD-CM	Case Management	ASLT-AP	Anatomy and Physiology
ABXD-CUL	Cultural/Spiritual Aspects of Health	ASLT-BH	Behavioral and Emotional Health
ABXD-DP	Disease Process	ASLT-C	Complications
ABXD-EQ	Equipment	ASLT-FU	Follow-up
ABXD-FU	Follow-up	ASLT-HELP	Help Line
ABXD-HY	Hygiene	ASLT-IR	Information and Referral
ABXD-ISO	Isolation	ASLT-L	Literature
ABXD-L	Literature	ASLT-M	Medications
ABXD-M	Medications	ASLT-P	Prevention
ABXD-MNT	Medical Nutrition Therapy	ASLT-PRO	Procedures
ABXD-N	Nutrition	ASLT-RI	Patient Rights and Responsibilities
ABXD-P	Prevention	ASLT-RP	Mandatory Reporting
ABXD-PRO	Procedures	ASLT-S	Safety
ABXD-TE	Tests	ASLT-TE	Tests
ABXD-TX	Treatment	ASLT-TX	Treatment
ABX	ANTIBIOTIC RESISTANCE		
ABX-C	Complications		
ABX-DP	Disease Process		
ABX-FU	Follow-up		
ABX-L	Literature		
ABX-M	Medications		
ABX-P	Prevention		

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ASM	ASTHMA	ADHD	ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER
AMS-AP	Anatomy and Physiology	ADHD-C	Complications
ASM-C	Complications	ADHD-CM	Case Management
ASM-CM	Case Management	ADHD-DP	Disease Process
ASM-CUL	Cultural/Spiritual Aspects of Health	ADHD-FU	Follow-up
ASM-DP	Disease Process	ADHD-GD	Growth and Development
ASM-EQ	Equipment	ADHD-HELP	Help Line
ASM-EX	Exercise	ADHD-IR	Information and Referral
ASM-FU	Follow-up	ADHD-L	Literature
ASM-HELP	Help Line	ADHD-LA	Lifestyle Adaptations
ASM-HM	Home Management	ADHD-M	Medications
ASM-L	Literature	ADHD-MNT	Medical Nutrition Therapy
ASM-LA	Lifestyle Adaptations	ADHD-N	Nutrition
ASM-M	Medications	ADHD-PSY	Psychotherapy
ASM-MDI	Metered-Dose Inhalers	ADHD-TE	Tests
ASM-MNT	Medical Nutrition Therapy	ADHD-TX	Treatment
ASM-N	Nutrition		
ASM-NEB	Nebulizer	ATO	AUTOIMMUNE DISORDERS
ASM-PF	Peak-Flow Meter	ATO-ADV	Advance Directive
ASM-SHS	Second-Hand/Third-Hand Smoke	ATO-AP	Anatomy and Physiology
ASM-SM	Stress Management	ATO-BH	Behavioral and Emotional Health
ASM-SMP	Self Management Plan	ATO-C	Complications
ASM-SPA	Spacers	ATO-CM	Care Management
ASM-TE	Tests	ATO-DP	Disease Process
ASM-TO	Tobacco (Smoking)	ATO-FU	Follow-up
ASM-TX	Treatment	ATO-HELP	Help Line
		ATO-HM	Home Management
ADD	ATTENTION DEFICIT HYPERACTIVITY DISORDER (SEE ADHD - ATTENTION- DEFICIT/ HYPERACTIVITY DISORDER)	ATO-HPDP	Health Promotion, Disease Prevention
		ATO-L	Literature
		ATO-LA	Lifestyle Adaptations
		ATO-M	Medications
		ATO-MNT	Medical Nutrition Therapy
		ATO-N	Nutrition
		ATO-PCC	Pre-Conception Care
		ATO-PM	Pain Management
		ATO-PRO	Procedure
		ATO-PSY	Psychotherapy
		ATO-SM	Stress Management
		ATO-TE	Tests
		ATO-TX	Treatment

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BH	BEHAVIORAL AND SOCIAL HEALTH	BWP	BIOLOGICAL WEAPONS
BH-ADL	Activities of Daily Living	BWP-C	Complications
BH-ADV	Advance Directive	BWP-CUL	Cultural/Spiritual Aspects of Health
BH-CM	Case Management	BWP-DP	Disease Process
BH-CUL	Cultural/Spiritual Aspects of Health	BWP-FU	Follow-up
BH-DP	Disease Process	BWP-I	Information
BH-EQ	Equipment	BWP-L	Literature
BH-EX	Exercise	BWP-LA	Lifestyle Adaptations
BH-FU	Follow-up	BWP-M	Medications
BH-GP	Grieving Process	BWP-P	Prevention
BH-HELP	Help Line	BWP-SM	Stress Management
BH-HM	Health Promotion, Disease Prevention	BWP-TE	Tests
BH-HOU	Housing	BWP-TX	Treatment
BH-HPDP	Health Promotion, Disease Prevention	BD	BIPOLAR DISORDERS
BH-HY	Hygiene	BD-C	Complications
BH-IB	Insurance/Benefits	BD-CM	Case Management
BH-IR	Information and Referral	BD-CUL	Cultural/Spiritual Aspects of Health
BH-L	Literature	BD-DP	Disease Process
BH-LA	Lifestyle Adaptations	BD-EX	Exercise
BH-M	Medications	BD-FU	Follow-up
BH-PA	Parenting	BH-HPDP	Health Promotion, Disease Prevention
BH-PLC	Placement	BD-IR	Information and Referral
BH-PRO	Procedure	BD-L	Literature
BH-PSY	Psychotherapy	BD-LA	Lifestyle Adaptations
BH-RI	Patient Rights and Responsibilities	BD-M	Medications
BH-S	Safety	BD-MNT	Medical Nutrition Therapy
BH-SM	Stress Management	BD-N	Nutrition
BH-TE	Test/Screening	BD-PCC	Pre-Conception Care
BH-TLH	Tele-Health	BD-PSY	Psychotherapy
BH-TR	Transportation	BD-S	Safety
BELL	BELL'S PALSY	BD-SM	Stress Management
BELL-AP	Anatomy and Physiology	BD-THL	Tele-Health
BELL-C	Complications	BD-TE	Tests
BELL-DP	Disease Process	BD-TX	Treatment
BELL-FU	Follow-up		
BELL-HELP	Help Line		
BELL-L	Literature		
BELL-M	Medications		
BELL-PM	Pain Management		
BELL-TE	Tests		
BELL-TX	Treatment		

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BITE	BITES, ANIMAL AND HUMAN	BF	BREASTFEEDING
BITE-AP	Anatomy and Physiology	BF-AP	Anatomy and Physiology
BITE-C	Complications	BF-BB	Benefits of Breastfeeding
BITE-CUL	Cultural/Spiritual Aspects of Health	BF-BC	Breast Care
BITE-DP	Disease Process	BF-BP	Breastfeeding Positions
BITE-FU	Follow-up	BF-CS	Collection and Storage of Breast Milk
BITE-HY	Hygiene	BF-CUL	Cultural/Spiritual Aspects of Health
BITE-L	Literature	BF-EQ	Equipment
BITE-M	Medications	BF-FU	Follow-up
BITE-P	Prevention	BF-GD	Growth and Development
BITE-PM	Pain Management	BF-HELP	Help Line
BITE-TE	Tests	BF-HC	Hunger Cues
BITE-TX	Treatment	BF-L	Literature
BL	BLOOD TRANSFUSION	BF-LA	Lifestyle Adaptations
BL-C	Complications	BF-M	Maternal Medications
BL-EQ	Equipment	BF-MK	Milk Intake
BL-FU	Follow-up	BF-MNT	Medical Nutrition Therapy
BL-L	Literature	BF-N	Nutrition (Maternal)
BL-S	Safety	BF-NJ	Neonatal Jaundice
BL-TE	Tests	BF-ON	Latch-on
BL-TX	Treatment	BF-SF	Introduction to Solid Foods
		BF-SM	Stress Management
		BF-T	Teething
		BF-W	Weaning
		BURN	BURNS
		BURN-BH	Behavioral and Emotional Health
		BURN-C	Complications
		BURN-CUL	Cultural/Spiritual Aspects of Health
		BURN-DP	Disease Process
		BURN-FU	Follow-up
		BURN-HY	Hygiene
		BURN-L	Literature
		BURN-M	Medications
		BURN-MNT	Medical Nutrition Therapy
		BURN-N	Nutrition
		BURN-P	Prevention
		BURN-PM	Pain Management
		BURN-TX	Treatment
		BURN-WC	Wound Care

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CA CANCER

CA-ADV	Advance Directive
CA-AP	Anatomy and Physiology
CA-BH	Behavioral and Emotional Health
CA-C	Complications
CA-CM	Case Management
CA-CUL	Cultural/Spiritual Aspects of Health
CA-DP	Disease Process
CA-EQ	Equipment
CA-EX	Exercise
CA-FU	Follow-up
CA-HELP	Help Line
CA-HM	Home Management
CA-HPDP	Health Promotion, Disease Prevention
CA-HY	Hygiene
CA-L	Literature
CA-LA	Lifestyle Adaptations
CA-M	Medications
CA-MNT	Medical Nutrition Therapy
CA-N	Nutrition
CA-P	Prevention
CA-PCC	Pre-Conception Care
CA-PM	Pain Management
CA-PRO	Procedure
CA-REF	Referral
CA-SM	Stress Management
CA-TE	Tests
CA-TX	Treatment

**CEL CELIAC DISEASE (SEE
 CELIAC - CELIAC DISEASE)**

CELIAC CELIAC DISEASE

CELIAC-AP	Anatomy and Physiology
CELIAC-BH	Behavioral and Emotional Health
CELIAC-C	Complications
CELIAC-CM	Case Management
CELIAC-DP	Disease Process
CELIAC-FU	Follow-up
CELIAC-HELP	Help Line
CELIAC-L	Literature
CELIAC-LA	Lifestyle Adaptations
CELIAC-M	Medications
CELIAC-MNT	Medical Nutrition Therapy
CELIAC-N	Nutrition
CELIAC-PCC	Pre-Conception Care
CELIAC-TE	Tests
CELIAC-TX	Treatment

CVC CENTRAL LINE CATHETER

CVC-C	Complications
CVC-DP	Disease Process
CVC-EQ	Equipment
CVC-FU	Follow-up
CVC-HM	Home Management
CVC-HY	Hygiene
CVC-L	Literature
CVC-M	Medications
CVC-PRO	Procedure
CVC-TE	Tests
CVC-WC	Wound Care

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CERP	CEREBRAL PALSY	CVA	CEREBROVASCULAR DISEASE
CERP-ADL	Activities of Daily Living	CVA-ADV	Advance Directive
CERP-AP	Anatomy and Physiology	CVA-AP	Anatomy and Physiology
CERP-BH	Behavioral and Emotional Health	CVA-BH	Behavioral and Emotional Health
CERP-C	Complications	CVA-C	Complications
CERP-CM	Case Management	CVA-CM	Case Management
CERP-CUL	Cultural/Spiritual Aspects of Health	CVA-CUL	Cultural/Spiritual Aspects of Health
CERP-DP	Disease Process	CVA-DP	Disease Process
CERP-EQ	Equipment	CVA-EQ	Equipment
CERP-EX	Exercise	CVA-EX	Exercise
CERP-FU	Follow-up	CVA-FU	Follow-up
CERP-GD	Growth and Development	CVA-HELP	Help Line
CERP-HELP	Help Line	CVA-HPDP	Health Promotion, Disease Prevention
CERP-HM	Home Management	CVA-HM	Home Management
CERP-HPDP	Health Promotion, Disease Prevention	CVA-HY	Hygiene
CERP-L	Literature	CVA-L	Literature
CERP-LA	Lifestyle Adaptations	CVA-LA	Lifestyle Adaptations
CERP-M	Medications	CVA-M	Medications
CERP-MNT	Medical Nutrition Therapy	CVA-MNT	Medical Nutrition Therapy
CERP-N	Nutrition	CVA-N	Nutrition
CERP-P	Prevention	CVA-P	Prevention
CERP-PM	Pain Management	CVA-PRO	Procedure
CERP-PRO	Procedure	CVA-S	Safety
CERP-S	Safety	CVA-SCR	Screening
CERP-SHS	Second-Hand/Third-Hand Smoke	CVA-SM	Stress Management
CERP-SM	Stress Management	CVA-TE	Tests
CERP-TE	Tests	CVA-TX	Treatment
CERP-TX	Treatment		

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CWP CHEMICAL WEAPONS

CWP-AP	Anatomy and Physiology
CWP-BH	Behavioral and Emotional Health
CWP-C	Complications
CWP-CM	Case Management
CWP-CUL	Cultural/Spiritual Aspects of Health
CWP-DP	Disease Process
CWP-EX	Exercise
CWP-FU	Follow-up
CWP-HELP	Help Line
CWP-L	Literature
CWP-M	Medications
CWP-MNT	Medical Nutrition Therapy
CWP-P	Prevention and Decontamination
CWP-TE	Tests
CWP-TX	Treatment

CP CHEST PAIN

CP-AP	Anatomy and Physiology
CP-C	Complications
CP-DP	Disease Process
CP-EQ	Equipment
CP-EX	Exercise
CP-FU	Follow-up
CP-L	Literature
CP-LA	Lifestyle Adaptations
CP-M	Medications
CP-MNT	Medical Nutrition Therapy
CP-N	Nutrition
CP-P	Prevention
CP-PM	Pain Management
CP-PRO	Procedure
CP-SM	Stress Management
CP-TE	Tests
CP-TX	Treatment

CHN CHILD HEALTH NEWBORN (0-60 DAYS)

CHN-CAR	Car Seats and Automobile Safety
CHN-CUL	Cultural/Spiritual Aspects of Health
CHN-ECC	Early Childhood Caries
CHN-FU	Follow-up
CHN-GD	Growth and Development
CHN-HELP	Help Line
CHN-HPDP	Health Promotion, Disease Prevention
CHN-HY	Hygiene
CHN-IM	Immunizations
CHN-L	Literature
CHN-MNT	Medical Nutrition Therapy
CHN-N	Nutrition
CHN-NJ	Neonatal Jaundice
CHN-PA	Parenting
CHN-S	Safety
CHN-SCR	Screening
CHN-SF	Introduction to Solid Foods
CHN-SHS	Second-Hand/Third-Hand Smoke

CHI CHILD HEALTH INFANT (2-12 MONTHS)

CHI-CAR	Car Seats and Automobile Safety
CHI-CUL	Cultural/Spiritual Aspects of Health
CHI-ECC	Early Childhood Caries
CHI-ECL	Early Childhood Literacy
CHI-FU	Follow-up
CHI-GD	Growth and Development
CHI-HELP	Help Line
CHI-HPDP	Health Promotion, Disease Prevention
CHI-HY	Hygiene
CHI-IM	Immunizations
CHI-L	Literature
CHI-MNT	Medical Nutrition Therapy
CHI-N	Nutrition
CHI-PA	Parenting
CHI-S	Safety
CHI-SF	Introduction to Solid Foods
CHI-SHS	Second-Hand/Third-Hand Smoke
CHI-W	Weaning

INDEX OF PATIENT EDUCATION PROTOCOLS

CHT	CHILD HEALTH TODDLER (1-3 YEARS)	CHS	CHILD HEALTH SCHOOL AGE (5-12 YEARS)
CHT-CAR	Car Seats and Automobile Safety	CHS-AOD	Alcohol and Other Drugs
CHT-CUL	Cultural/Spiritual Aspects of Health	CHS-CAR	Car Seats and Automobile Safety
CHT-ECC	Early Childhood Caries	CHS-CUL	Cultural/Spiritual Aspects of Health
CHT-ECL	Early Childhood Literacy	CHS-DC	Dental Care
CHT-FU	Follow-up	CHS-ECC	Early Childhood Caries
CHT-GD	Growth and Development	CHS-ECL	Early Childhood Literacy
CHT-HPDP	Health Promotion, Disease Prevention	CHS-EX	Exercise
CHT-HY	Hygiene	CHS-FU	Follow-up
CHT-IM	Immunizations	CHS-GD	Growth and Development
CHT-L	Literature	CHS-HY	Hygiene
CHT-MNT	Medical Nutrition Therapy	CHS-IM	Immunizations
CHT-N	Nutrition	CHS-L	Literature
CHT-PA	Parenting	CHS-MNT	Medical Nutrition Therapy
CHT-S	Safety	CHS-N	Nutrition
CHT-SHS	Second-Hand/Third Hand Smoke	CHS-PA	Parenting
CHT-W	Weaning	CHS-PCC	Pre-Conception Care
		CHS-S	Safety
		CHS-SHS	Second-Hand/Third-Hand Smoke
CHP	CHILD HEALTH PRESCHOOL (3-5 YEARS)	CHS-SOC	Social Health
CHP-CAR	Car Seats and Automobile Safety	CHS-SX	Sexuality
CHP-CUL	Cultural/Spiritual Aspects of Health	CHS-TO	Tobacco
CHP-ECC	Early Childhood Caries		
CHP-ECL	Early Childhood Literacy		
CHP-FU	Follow-up		
CHP-GD	Growth and Development		
CHP-HELP	Help Line		
CHP-HPDP	Health Promotion, Disease Prevention		
CHP-HY	Hygiene		
CHP-IM	Immunizations		
CHP-L	Literature		
CHP-MNT	Medical Nutrition Therapy		
CHP-N	Nutrition		
CHP-PA	Parenting		
CHP-S	Safety		
CHP-SHS	Second-Hand/Third-Hand Smoke		

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CHA	CHILD HEALTH ADOLESCENT (12-18 YEARS)	CB	CHILDBIRTH
CHA-AOD	Alcohol and Other Drugs	CB-ADV	Advance Directive
CHA-BH	Behavioral and Emotional Health	CB-AP	Anatomy and Physiology
CHA-CAR	Automobile Safety	CN-BH	Behavioral and Emotional Health
CHA-CUL	Cultural/Spiritual Aspects of Health	CB-C	Complications
CHA-DC	Dental Care	CB-CUL	Cultural/Spiritual Aspects of Health
CHA-EX	Exercise	CB-EQ	Equipment
CHA-FU	Follow-up	CB-EX	Exercises, Relaxation & Breathing
CHA-GD	Growth and Development	CB-FU	Follow-up
CHA-HPDP	Health Promotion, Disease Prevention	CB-HELP	Help Line
CHA-HY	Hygiene	CB-HY	Hygiene
CHA-IM	Immunizations	CB-ISEC	Infant Safety
CHA-L	Literature	CB-L	Literature
CHA-MNT	Medical Nutrition Therapy	CB-LB	Labor Signs
CHA-MS	Menses	CB-M	Medications
CHA-N	Nutrition	CB-NJ	Neonatal Jaundice
CHA-PA	Parenting	CB-OR	Orientation
CHA-PCC	Pre-Conception Care	CB-PM	Pain Management
CHA-S	Safety	CB-PRO	Procedures, Obstetrical
CHA-SHS	Second-Hand/Third-Hand Smoke	CB-RO	Role of Labor and Delivery Partner/Coach
CHA-SOC	Social Health	CB-TE	Tests
CHA-SM	Stress Management	CB-VBAC	Vaginal Birth after Cesarean Section
CHA-SX	Sexuality		
CHA-TO	Tobacco		

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CKD	CHRONIC KIDNEY DISEASE	COPD	CHRONIC OBSTRUCTIVE PUMONARY DISEASE
CKD-ADV	Advance Directive	COPD-ADV	Advance Directive
CKD-AP	Anatomy and Physiology	COPD-AP	Anatomy and Physiology
CKD-BH	Behavioral and Emotional Health	COPD-BH	Behavioral and Emotional Health
CKD-C	Complications	COPD-C	Complications
CKD-CM	Case Management	COPD-CM	Case Management
CKD-CUL	Cultural/Spiritual Aspects of Health	COPD-CUL	Cultural/Spiritual Aspects of Health
CKD-DIA	Dialysis	COPD-DP	Disease Process
CKD-DP	Disease Process	COPD-EQ	Equipment
CKD-EQ	Equipment	COPD-EX	Exercise
CKD-FU	Follow-up	COPD-FU	Follow-Up
CKD-HELP	Help Line	COPD-HM	Home Management
CKD-L	Literature	COPD-HY	Hygiene
CKD-LA	Lifestyle Adaptations	COPD-IS	Incentive Spirometry
CKD-M	Medications	COPD-L	Literature
CKD-MNT	Medical Nutrition Therapy	COPD-LA	Lifestyle Adaptations
CKD-N	Nutrition	COPD-M	Medications
CKD-P	Prevention	COPD-MDI	Metered-Dose Inhalers
CKD-PCC	Pre-Conception Care	COPD-MNT	Medical Nutrition Therapy
CKD-PRO	Procedures	COPD-N	Nutrition
CKD-REF	Referral	COPD-P	Prevention
CKD-TE	Tests	COPD-PRO	Procedure
CKD-TX	Treatment	COPD-SHS	Second-Hand/Third-Hand Smoke
		COPD-TE	Tests
		COPD-TO	Tobacco (Smoking)

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COG	COGNITIVE DISORDER	CPM	CHRONIC PAIN
COG-ADL	Activities of Daily Livinge	CPM-AP	Anatomy and Physiology
COG-AP	Anatomy and Physiology	CPM-BH	Behavioral and Emotional Health
COG-BH	Behavioral and Emotional Health	CPM-CM	Case Management
COG-C	Complications	CPM-CUL	Cultural/Spiritual Aspects of Health
COG-CM	Case Management	CPM-DP	Disease Process
COG-CUL	Cultural/Spiritual Aspects of Health	CPM-EQ	Equipment
COG-DP	Disease Process	CPM-EX	Exercise
COG-FU	Follow-Up	CPM-FU	Follow-Up
COG-HELP	Help Line	CPM-HPDP	Health Promotion, Disease Prevention
COG-HM	Home Management	CPM-IR	Information and Referral
COG-HPDP	Health Promotion, Disease Prevention	CPM-L	Literature
COG-L	Literature	CPM-LA	Lifestyle Adaptations
COG-LA	Lifestyle Adaptations	CPM-M	Medications
COG-M	Medications	CPM-MNT	Medical Nutrition Therapy
COG-MNT	Medical Nutrition Therapy	CPM-N	Nutrition
COG-N	Nutrition	CPM-P	Prevention
COG-S	Safety	CPM-PM	Pain Management
COG-SM	Stress Management	CPM-PSY	Psychotherapy
COG-TE	Tests	CPM-S	Safety
COG-TLH	Tele-Health	CPM-SM	Stress Management
COG-TX	Treatment	CPM-TE	Tests
		CPM-TX	Treatment
		CDC	COMMUNICABLE DISEASES
		CDC-AP	Anatomy and Physiology
		CDC-C	Complications
		CDC-CM	Case Management
		CDC-DP	Disease Process
		CDC-EQ	Equipment
		CDC-FU	Follow-up
		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
		CDC-WC	Wound Care

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COND	CONDUCT DISORDER	CAD	CORONARY ARTERY DISEASE
COND-C	Complications	CAD-ADV	Advance Directive
COND-CM	Case Management	CAD-AP	Anatomy and Physiology
COND-CUL	Cultural/Spiritual Aspects of Health	CAD-BH	Behavioral and Emotional Health
COND-DP	Disease Process	CAD-C	Complications
COND-EX	Exercise	CAD-CM	Case Management
COND-FU	Follow-Up	CAD-CUL	Cultural/Spiritual Aspects of Health
COND-HPDP	Health Promotion, Disease Prevention	CAD-DP	Disease Process
COND-IR	Information and Referral	CAD-EQ	Equipment
COND-L	Literature	CAD-EX	Exercise
COND-LA	Lifestyle Adaptations	CAD-FU	Follow-up
COND-M	Medications	CAD-HELP	Help Line
COND-PA	Parenting	CAD-L	Literature
COND-PSY	Psychotherapy	CAD-LA	Lifestyle Adaptations
COND-S	Safety	CAD-M	Medications
COND-SM	Stress Management	CAD-MNT	Medical Nutrition Therapy
COND-TLH	Tele-Health	CAD-N	Nutrition
COND-TX	Treatment	CAD-P	Prevention
CHF	CONGESTIVE HEART FAILURE (SEE HF-HEART FAILURE)	CAD-PM	Pain Management
CO	CONSTIPATION	CAD-PRO	Procedures
CO-AP	Anatomy and Physiology	CAD-SM	Stress Management
CO-C	Complications	CAD-TE	Tests
CO-DP	Disease Process	CAD-TO	Tobacco (Smoking)
CO-EX	Exercise	CAD-TX	Treatment
CO-FU	Follow-up		
CO-HPDP	Health Promotion, Disease Prevention		
CO-HY	Hygiene		
CO-L	Literature		
CO-LA	Lifestyle Adaptations		
CO-M	Medications		
CO-MNT	Medical Nutrition Therapy		
CO-N	Nutrition		
CO-P	Prevention		
CO-PRO	Procedures		
CO-TE	Tests		
CO-TX	Treatment		

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CRIT	CRITICAL CARE	CRN	CROHN'S DISEASE
CRIT-ADV	Advance Directive	CRN-AP	Anatomy and Physiology
CRIT-BH	Behavioral and Emotional Health	CRN-BH	Behavioral and Emotional Health
CRIT-BIP	Bilevel (or Continuous) Positive Airway Pressure Ventilation	CRN-C	Complications
CRIT-C	Complications	CRN-CM	Case Management
CRIT-CM	Case Management	CRN-CUL	Cultural/Spiritual Aspects of Health
CRIT-CUL	Cultural/Spiritual Aspects of Health	CRN-DP	Disease Process
CRIT-DIA	Dialysis	CRN-EX	Exercise
CRIT-EQ	Equipment	CRN-FU	Follow-up
CRIT-FU	Follow-Up	CRN-HELP	Help Line
CRIT-HY	Hygiene	CRN-HM	Home Management
CRIT-INT	Intubation	CRN-L	Literature
CRIT-IS	Incentive spirometry	CRN-LA	Lifestyle Adaptations
CRIT-ISO	Isolation	CRN-M	Medications
CRIT-L	Literature	CRN-MNT	Medical Nutrition Therapy
CRIT-LA	Lifestyle Adaptations	CRN-N	Nutrition
CRIT-M	Medications	CRN-P	Prevention
CRIT-MNT	Medical Nutrition Therapy	CRN-PCC	Pre-Conception Care
CRIT-MON	Monitoring	CRN-PM	Pain Management
CRIT-N	Nutrition	CRN-PRO	Procedure
CRIT-O2	Oxygen Therapy	CRN-SM	Stress Management
CRIT-P	Prevention	CRN-TE	Tests
CRIT-PM	Pain Management	CRN-TX	Treatment
CRIT-PRO	Procedure	CRP	CROUP
CRIT-PT	Physical Therapy	CRP-AP	Anatomy and Physiology
CRIT-SM	Stress Management	CRP-C	Complications
CRIT-TE	Tests	CRP-DP	Disease Process
CRIT-TX	Treatment	CRP-EQ	Equipment
CRIT-WC	Wound Care	CRP-FU	Follow-up
		CRP-HM	Home Management
		CRP-L	Literature
		CRP-M	Medications
		CRP-SHS	Second-Hand/Third-Hand Smoke
		CRP-TX	Treatment

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CF	CYSTIC FIBROSIS	DEH	DEHYDRATION
CF-AP	Anatomy and Physiology	DEH-AP	Anatomy and Physiology
CF-BH	Behavioral and Emotional Health	DEH-C	Complications
CF-C	Complications	DEH-DP	Disease Process
CF-CM	Case Management	DEH-EX	Exercise
CF-CUL	Cultural/Spiritual Aspects of Health	DEH-FU	Follow-up
CF-DP	Disease Process	DEH-HPDP	Health Promotion, Disease Prevention
CF-EQ	Equipment	DEH-L	Literature
CF-EX	Exercise	DEH-MNT	Medical Nutrition Therapy
CF-FU	Follow-up	DEH-N	Nutrition
CF-HELP	Help Line	DEH-P	Prevention
CF-HM	Home Management	DEH-TX	Treatment
CF-L	Literature		
CF-LA	Lifestyle Adaptations	DEL	DELIRIUM
CF-M	Medications	DEL-BH	Behavioral and Emotional Health
CF-MNT	Medical Nutrition Therapy	DEL-C	Complications
CF-N	Nutrition	DEL-CM	Case Management
CF-PCC	Pre-Conception Care	DEL-CUL	Cultural/Spiritual Aspects of Health
CF-SHS	Second-Hand/Third-Hand Smoke	DEL-DP	Disease Process
CF-SM	Stress Management	DEL-EX	Exercise
CF-TE	Tests	DEL-FU	Follow-up
CF-TO	Tobacco (Smoking)	DEL-HY	Hygiene
CF-TX	Treatment	DEL-L	Literature
		DEL-M	Medications
DVT	DEEP VEIN THROMBOSIS	DEL-MNT	Medical Nutrition Therapy
DVT-AP	Anatomy and Physiology	DEL-N	Nutrition
DVT-C	Complications	DEL-P	Prevention
DVT-DP	Disease Process	DEL-S	Safety
DVT-EX	Exercise	DEL-SM	Stress Management
DVT-FU	Follow-up	DEL-TE	Tests
DVT-L	Literature	DEL-TX	Treatment
DVT-M	Medications		
DVT-MNT	Medical Nutrition Therapy		
DVT-N	Nutrition		
DVT-P	Prevention		
DVT-PCC	Pre-Conception Care		
DVT-TE	Tests		
DVT-TX	Treatment		

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DEM	DEMENTIA	DEP	DEPRESSIVE DISORDERS
DEM-ADL	Activities of Daily Living	DEP-C	Complications
DEM-ADV	Advance Directive	DEP-CM	Case Management
DEM-BH	Behavioral and Emotional Health	DEP-CUL	Cultural/Spiritual Aspects of Health
DEM-C	Complications		
DEM-CM	Case Management	DEP-DP	Disease Process
DEM-CUL	Cultural/Spiritual Aspects of Health	DEP-EX	Exercise
		DEP-FU	Follow-up
DEM-DP	Disease Process	DEP-HELP	Help Line
DEM-EX	Exercise	DEP-HPDP	Health Promotion, Disease Prevention
DEM-FU	Follow-up		
DEM-HELP	Help Line	DEP-IR	Information and Referral
DEM-HM	Home Management	DEP-L	Literature
DEM-HPDP	Health Promotion, Disease Prevention	DEP-LA	Lifestyle Adaptations
		DEP-M	Medications
DEM-HY	Hygiene	DEP-MNT	Medical Nutrition Therapy
DEM-L	Literature	DEP-N	Nutrition
DEM-LA	Lifestyle Adaptations	DEP-P	Prevention
DEM-M	Medications	DEP-PSY	Psychotherapy
DEM-MNT	Medical Nutrition Therapy	DEP-S	Safety
DEM-N	Nutrition	DEP-SM	Stress Management
DEM-PLC	Placement	DEP-TLH	Tele-Health
DEM-S	Safety	DEP-TX	Treatment
DEM-SM	Stress Management		
DEM-TE	Tests		
DEM-TLH	Tele-Health		
DEM-TX	Treatment		

DC	DENTAL CARIES
DC-AP	Anatomy and Physiology
DC-C	Complications
DC-DP	Disease Process
DC-FU	Follow-up
DC-HPDP	Health Promotion, Disease Prevention
DC-HY	Hygiene
DC-L	Literature
DC-M	Medications
DC-N	Nutrition
DC-P	Prevention
DC-PM	Pain Management
DC-PRO	Procedures
DC-TE	Tests
DC-TO	Tobacco
DC-TX	Treatment
DC-WC	Wound Care

INDEX OF PATIENT EDUCATION PROTOCOLS

DM	DIABETES MELLITUS	DIA	DIALYSIS
DM-AP	Anatomy and Physiology	DIA-ADV	Advance Directive
DM-BH	Behavioral and Emotional Health	DIA-AP	Anatomy and Physiology
DM-C	Complications	DIA-BH	Behavioral and Emotional Health
DM-CM	Case Management	DIA-C	Complications
DM-CUL	Cultural/Spiritual Aspects of Health	DIA-CM	Case Management
DM-DP	Disease Process	DIA-CUL	Cultural/Spiritual Aspects of Health
DM-EQ	Equipment	DIA-DP	Disease Process
DM-EX	Exercise	DIA-EQ	Equipment
DM-FTC	Foot Care and Examinations	DIA-EX	Exercise
DM-FU	Follow-up	DIA-FU	Follow-up
DM-HELP	Help Line	DIA-HELP	Help Line
DM-HM	Home Management	DIA-HM	Home Management
DM-KID	Kidney Disease	DIA-HY	Hygiene
DM-L	Literature	DIA-L	Literature
DM-LA	Lifestyle Adaptations	DIA-LA	Lifestyle Adaptations
DM-M	Medications	DIA-M	Medications
DM-MNT	Medical Nutrition Therapy	DIA-MNT	Medical Nutrition Therapy
DM-N	Nutrition	DIA-N	Nutrition
DM-P	Prevention	DIA-P	Prevention
DM-PCC	Pre-Conception Care	DIA-PRO	Procedures
DM-PERIO	Periodontal Disease	DIA-REF	Referral
DM-PM	Pain Management	DIA-TE	Tests
DM-S	Safety	DIA-TX	Treatment
DM-SCR	Screening		
DM-SM	Stress Management		
DM-TE	Tests		
DM-TX	Treatment		
DM-WC	Wound Care		

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DCH	DISCHARGE FROM HOSPITAL	DIV	DIVERTICULITIS / DIVERTICULOSIS
DCH-BH	Behavioral and Emotional Health	DIV-AP	Anatomy and Physiology
DCH-CM	Case Management	DIV-C	Complications
DCH-EQ	Equipment	DIV-DP	Disease Process
DCH-EX	Exercise	DIV-EX	Exercise
DCH-FU	Follow-up	DIV-FU	Follow-up
DCH-HM	Home Management	DIV-L	Literature
DCH-IB	Insurance and Benefits	DIV-LA	Lifestyle Adaptations
DCH-HELP	Help Line	DIV-M	Medications
DCH-L	Literature	DIV-MNT	Medical Nutrition Therapy
DCH-LA	Lifestyle Adaptations	DIV-N	Nutrition
DCH-M	Medications	DIV-P	Prevention
DCH-MNT	Medical Nutrition Therapy	DIV-PM	Pain Management
DCH-N	Nutrition	DIV-PRO	Procedures
DCH-POC	Plan of Care	DIV-TE	Tests
DCH-PRO	Procedures	DIV-TX	Treatment
DCH-REF	Referral		
DCH-RI	Patient Rights and Responsibilities	DV	DOMESTIC VIOLENCE (SEE DVP OR DVV)
DCH-S	Safety		
DCH-TE	Tests		
DCH-TX	Treatment	DVP	DOMESTIC VIOLENCE, PERPETRATOR
DISSD	DISSOCIATIVE DISORDER	DVP-CUL	Cultural/Spiritual Aspects of Health
DISSD-C	Complications	DVP-DP	Disease Process
DISSD-CM	Case Management	DVP-FU	Follow-up
DISSD-CUL	Cultural/Spiritual Aspects of Health	DVP-IR	Information and Referral
DISSD-DP	Disease Process	DVP-L	Literature
DISSD-EX	Exercise	DVP-P	Prevention
DISSD-FU	Follow-up	DVP-PSY	Psychotherapy
DISSD-HPDP	Health Promotion, Disease Prevention	DVP-S	Safety
DISSD-L	Literature	DVP-SM	Stress Management
DISSD-LA	Lifestyle Adaptations	DVP-TX	Treatment
DISSD-M	Medications		
DISSD-PSY	Psychotherapy		
DISSD-S	Safety		
DISSD-SM	Stress Management		
DISSD-TLH	Tele-Health		
DISSD-TX	Treatment		

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DVV DOMESTIC VIOLENCE, VICTIM

DVV-C	Complications
DVV-CUL	Cultural/Spiritual Aspects of Health
DVV-DP	Disease Process
DVV-FU	Follow-up
DVV-HELP	Help Line
DVV-IR	Information and Referral
DVV-L	Literature
DVV-P	Prevention
DVV-PSY	Psychotherapy
DVV-RP	Mandatory Reporting
DVV-S	Safety
DVV-SM	Stress Management
DVV-TX	Treatment

DYS DYSRHYTHMIAS

DYS-AP	Anatomy and Physiology
DYS-BH	Behavioral and Emotional Health
DYS-C	Complications
DYS-DP	Disease Process
DYS-EQ	Equipment
DYS-EX	Exercise
DYS-FU	Follow-up
DYS-HELP	Help Line
DYS-L	Literature
DYS-LA	Lifestyle Adaptations
DYS-M	Medications
DYS-MNT	Medical Nutrition Therapy
DYS-N	Nutrition
DYS-PRO	Procedures
DYS-TE	Tests
DYS-TX	Treatment

ECC EARLY CHILDHOOD CARIES

ECC-AP	Anatomy and Physiology
ECC-C	Complications
ECC-DP	Disease Process
ECC-FU	Follow-up
ECC-GD	Growth and Development
ECC-HY	Hygiene
ECC-L	Literature
ECC-LA	Lifestyle Adaptations
ECC-M	Medications
ECC-MNT	Medical Nutrition Therapy
ECC-N	Nutrition
ECC-P	Prevention
ECC-PM	Pain Management
ECC-PRO	Procedures
ECC-TE	Tests
ECC-TX	Treatment

EAT EATING DISORDERS

EAT-BH	Behavioral and Emotional Health
EAT-C	Complications
EAT-CM	Case Management
EAT-CUL	Cultural/Spiritual Aspects of Health
EAT-DP	Disease Process
EAT-EX	Exercise
EAT-FU	Follow-up
EAT-HELP	Help Line
EAT-HPDP	Health Promotion, Disease Prevention
EAT-IR	Information and Referral
EAT-L	Literature
EAT-LA	Lifestyle Adaptations
EAT-M	Medications
EAT-MNT	Medical Nutrition Therapy
EAT-N	Nutrition
EAT-P	Prevention
EAT-PA	Parenting
EAT-PCC	Pre-Conception Care
EAT-PSY	Psychotherapy
EAT-S	Safety
EAT-SCR	Screening
EAT-SM	Stress Management
EAT-TLH	Tele-Health
EAT-TX	Treatment

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ECZ ECZEMA / ATOPIC DERMATITIS

ECZ-AP	Anatomy and Physiology
ECZ-BH	Behavioral and Emotional Health
ECZ-C	Complications
ECZ-CM	Case Management
ECZ-CUL	Cultural/Spiritual Aspects of Health
ECZ-DP	Disease Process
ECZ-FU	Follow-up
ECZ-HELP	Help Line
ECZ-HM	Home Management
ECZ-HPDP	Health Promotion, Disease Prevention
ECZ-HY	Hygiene
ECZ-L	Literature
ECZ-M	Medications
ECZ-MNT	Medical Nutrition Therapy
ECZ-N	Nutrition
ECZ-P	Prevention
ECZ-SM	Stress Management
ECZ-WC	Wound Care

ELD ELDER CARE

ELD-ADV	Advance Directive
ELD-ANA	Abuse and Neglect - Adult
ELD-CM	Case Management
ELD-CUL	Cultural/Spiritual Aspects of Health
ELD-DP	Disease Process/Aging
ELD-EQ	Equipment
ELD-EX	Exercise
ELD-FU	Follow-up
ELD-HPDP	Health Promotion, Disease Prevention
ELD-HY	Hygiene
ELD-L	Literature
ELD-LA	Lifestyle Adaptations
ELD-M	Medications
ELD-MNT	Medical Nutrition Therapy
ELD-N	Nutrition
ELD-S	Safety
ELD-SM	Stress Management

ENC ENCEPHALITIS

ENCOP-ADV	Advance Directive
ENCOP-AP	Anatomy and Physiology
ENCOP-BH	Behavioral and Emotional Health
ENCOP-C	Complications
ENCOP-CM	Case Management
ENCOP-CUL	Cultural/Spiritual Aspects of Health
ENCOP-DP	Disease Process
ENCOP-EQ	Equipment
ENCOP-FU	Follow-up
ENCOP-HELP	Help Line
ENCOP-HM	Home Management
ENCOP-HPDP	Health Promotion, Disease Prevention
ENCOP-HY	Hygiene
ENCOP-L	Literature
ENCOP-LA	Lifestyle Adaptations
ENCOP-M	Medications
ENCOP-MNT	Medical Nutrition Therapy
ENCOP-N	Nutrition
ENCOP-P	Prevention
ENCOP-PM	Pain Management
ENCOP-PRO	Procedure
ENCOP-PSY	Psychotherapy
ENCOP-SM	Stress Management
ENCOP-TE	Tests
ENCOP-TLH	Tele-Health
ENCOP-TX	Treatment

ELEC ELECTROLYTE IMBALANCE

ELEC-C	Complication
ELEC-DP	Disease Process
ELEC-EX	Exercise
ELEC-FU	Follow-up
ELEC-L	Literature
ELEC-LA	Lifestyle Adaptations
ELEC-M	Medications
ELEC-MNT	Medical Nutrition Therapy
ELEC-N	Nutrition
ELEC-P	Procedure
ELEC-TE	Tests
ELEC-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

ENCOP ENCOPRESIS

ENCOP-AP	Anatomy and Physiology
ENCOP-C	Complications
ENCOP-CUL	Cultural/Spiritual Aspects of Health
ENCOP-DP	Disease Process
ENCOP-EX	Exercise
ENCOP-FU	Follow-up
ENCOP-HELP	Help Line
ENCOP-HPDP	Health Promotion, Disease Prevention
ENCOP-IR	Information and Referral
ENCOP-L	Literature
ENCOP-M	Medications
ENCOP-MNT	Medical Nutrition Therapy
ENCOP-N	Nutrition
ENCOP-PA	Parenting
ENCOP-PRO	Procedures
ENCOP-TE	Tests
ENCOP-TX	Treatment

EOL END OF LIFE

EOL-ADV	Advance Directive
EOL-BH	Behavioral and Emotional Health
EOL-CUL	Cultural/Spiritual Aspects of Health
EOL-DP	Disease Process
EOL-EQ	Equipment
EOL-FU	Follow-up
EOL-GP	Grieving Process
EOL-HM	Home Management
EOL-L	Literature
EOL-LA	Lifestyle Adaptations
EOL-M	Medications
EOL-N	Nutrition
EOL-PM	Pain Management
EOL-PSY	Psychotherapy
EOL-SM	Stress Management
EOL-TX	Treatment

ENU ENURESIS

ENU-AP	Anatomy and Physiology
ENU-BH	Behavioral and Emotional Health
ENU-C	Complications
ENU-CM	Case Management
ENU-CUL	Cultural/Spiritual Aspects of Health
ENU-DP	Disease Process
ENU-EQ	Equipment
ENU-EX	Exercise
ENU-FU	Follow-up
ENU-HELP	Help Line
ENU-HPDP	Health Promotion, Disease Prevention
ENU-HY	Hygiene
ENU-L	Literature
ENU-LA	Lifestyle Adaptations
ENU-M	Medications
ENU-MNT	Medical Nutrition Therapy
ENU-N	Nutrition
ENU-PA	Parenting
ENU-PSY	Psychotherapy
ENU-SM	Stress Management
ENU-TE	Tests
ENU-TX	Treatment

EYE EYE CONDITIONS

EYE-AP	Anatomy and Physiology
EYE-C	Complications
EYE-DP	Disease Process
EYE-FU	Follow-up
EYE-HM	Home Management
EYE-L	Literature
EYE-LA	Lifestyle Adaptations
EYE-M	Medications
EYE-P	Prevention
EYE-PM	Pain Management
EYE-PRO	Procedures
EYE-S	Safety
EYE-SCR	Screening
EYE-TE	Tests
EYE-TLH	Tele-Health
EYE-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

FACT FACTITIOUS DISORDER

FACT-C	Complications
FACT-CM	Case Management
FACT-CUL	Cultural/Spiritual Aspects of Health
FACT-DP	Disease Process
FACT-FU	Follow-up
FACT-HPDP	Health Promotion, Disease Prevention
FACT-IR	Information and Referral
FACT-L	Literature
FACT-LA	Lifestyle Adaptations
FACT-M	Medications
FACT-N	Nutrition
FACT-PSY	Psychotherapy
FACT-S	Safety
FACT-SM	Stress Management
FACT-TX	Treatment

FALL FALL

FALL-AP	Anatomy and Physiology
FALL-BH	Behavioral and Emotional Health
FALL-C	Complications
FALL-CC	Cast Care
FALL-DP	Disease Process
FALL-EQ	Equipment
FALL-EX	Exercise
FALL-FU	Follow-up
FALL-HM	Home Care
FALL-HPDP	Health Promotion, Disease Prevention
FALL-L	Literature
FALL-LA	Lifestyle Adaptations
FALL-P	Prevention
FALL-PM	Pain Management
FALL-S	Safety
FALL-SCR	Screening

FTT FAILURE TO THRIVE

FTT-ALL	Allergies
FTT-BH	Behavioral and Emotional Health
FTT-C	Complications
FTT-CUL	Cultural/Spiritual Aspects of Health
FTT-DP	Disease Process
FTT-EQ	Equipment
FTT-FU	Follow-up
FTT-HPDP	Health Promotion, Disease Prevention
FTT-HY	Hygiene
FTT-L	Literature
FTT-LA	Lifestyle Adaptations
FTT-M	Medications
FTT-MNT	Medical Nutrition Therapy
FTT-N	Nutrition
FTT-P	Prevention
FTT-PRO	Procedures
FTT-SM	Stress Management
FTT-TE	Tests
FTT-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

FP	FAMILY PLANNING	FEED	FEEDING DISORDERS OF INFANCY OR EARLY CHILDHOOD
FP-ABST	Abstinence		
FP-AP	Anatomy and Physiology		
FP-CUL	Cultural/Spiritual Aspects of Health	FEED-BH	Behavioral and Emotional Health
FP-DPH	Diaphragm	FEED-C	Complications
FP-DPO	Depot Medroxyprogesterone Injections	FEED-CM	Case Management
FP-EC	Emergency Contraception	FEED-DP	Disease Process
FP-FC	Foam and/or Condoms	FEED-FU	Follow-up
FP-FU	Follow-up	FEED-HELP	Help Line
FP-HELP	Help Line	FEED-HM	Home Management
FP-HPDP	Health Promotion, Disease Prevention	FEED-HPDP	Health Promotion, Disease Prevention
FP-HY	Hygiene	FEED-L	Literature
FP-IC	Implant Contraception	FEED-LA	Lifestyle Adaptations
FP-IR	Information and Referral	FEED-M	Medications
FP-IUD	Intrauterine Device	FEED-MNT	Medical Nutrition Therapy
FP-L	Literature	FEED-N	Nutrition
FP-M	Medications	FEED-P	Prevention
FP-MNT	Medical Nutrition Therapy	FEED-PA	Parenting
FP-MT	Methods	FEED-PSY	Psychotherapy
FP-N	Nutrition	FEED-SM	Stress Management
FP-OC	Oral Contraceptives	FEED-TE	Tests
FP-PCC	Pre-Conception Care	FEED-TLH	Tele-Health
FP-ST	Sterilization	FEED-TX	Treatment
FP-TD	Transdermal (Patch)		
FP-TE	Tests		

INDEX OF PATIENT EDUCATION PROTOCOLS

FASD	FETAL ALCOHOL SPECTRUM SYNDROME	FMS	FIBROMYALGIA SYNDROME
FASD-AP	Anatomy and Physiology	FMS-BH	Behavioral and Emotional Health
FASD-AOD	Alcohol and Other Drugs	FMS-CUL	Cultural/Spiritual Aspects of Health
FASD-ADL	Activities of Daily Living	FMS-DP	Disease Process
FASD-BH	Behavioral and Emotional Health	FMS-EX	Exercise
FASD-C	Complications	FMS-FU	Follow-up
FASD-CM	Case Management	FMS-HELP	Help Line
FASD-DP	Disease Process	FMS-L	Literature
FASD-FU	Follow-up	FMS-LA	Lifestyle Adaptations
FASD-GD	Growth and Development	FMS-M	Medications
FASD-HELP	Help Line	FMS-MNT	Medical Nutrition Therapy
FASD-HPDP	Health Promotion, Disease Prevention	FMS-N	Nutrition
FASD-IR	Information and Referral	FMS-PM	Pain Management
FASD-L	Literature	FMS-PSY	Psychotherapy
FASD-LA	Lifestyle Adaptations	FMS-SM	Stress Management
FASD-MNT	Medical Nutrition Therapy	FMS-TE	Tests
FASD-N	Nutrition	FMS-TX	Treatment
FASD-P	Prevention	FOOT	FOOT/PODIATRIC DISORDERS
FASD-PN	Prenatal	FOOT-AP	Anatomy and Physiology
FASD-TE	Tests	FOOT-C	Complications
F	FEVER	FOOT-DP	Disease Process
F-C	Complications	FOOT-FU	Follow-up
F-DP	Disease Process	FOOT-HM	Home Management
F-EQ	Equipment	FOOT-HY	Hygiene
F-FU	Follow-up	FOOT-L	Literature
F-HM	Home Management	FOOT-M	Medications
F-L	Literature	FOOT-P	Prevention
F-M	Medications	FOOT-PM	Pain Management
F-TE	Tests	FOOT-PRO	Procedures
F-TX	Treatment	FOOT-TE	Tests
		FOOT-TX	Treatment
		FOOT-WC	Wound Care
		FF	FORMULA FEEDING
		FF-FS	Formula Feeding Skills
		FF-HELP	Help Line
		FF-HY	Hygiene
		FF-L	Literature
		FF-MNT	Medical Nutrition Therapy
		FF-N	Nutrition
		FF-S	Safety

INDEX OF PATIENT EDUCATION PROTOCOLS

FRST	FROSTBITE	GER	GASTROESOPHAGEAL REFLUX DISEASE
FRST-C	Complications	GER-AP	Anatomy and Physiology
FRST-CUL	Cultural/Spiritual Aspects of Health	GER-C	Complications
FRST-DP	Disease Process	GER-CM	Case Management
FRST-FU	Follow-up	GER-DP	Disease Process
FRST-HPDP	Health Promotion, Disease Prevention	GER-EX	Exercise
FRST-L	Literature	GER-FU	Follow-up
FRST-M	Medications	GER-HPDP	Health Promotion, Disease Prevention
FRST-P	Prevention	GER-L	Literature
FRST-PM	Pain Management	GER-LA	Lifestyle Adaptations
FRST-TX	Treatment	GER-M	Medications
FRST-WC	Wound Care	GER-MNT	Medical Nutrition Therapy
		GER-N	Nutrition
GB	GALLBLADDER DISORDERS	GER-PM	Pain Management
GB-AP	Anatomy and Physiology	GER-SM	Stress Management
GB-BH	Behavioral and Emotional Health	GER-TE	Tests
GB-C	Complications	GER-TX	Treatment
GB-DP	Disease Process		
GB-FU	Follow-up	GENDR	GENDER DISORDER
GB-L	Literature	GENDR-C	Complications
GB-M	Medications	GENDR-CM	Case Management
GB-MNT	Medical Nutrition Therapy	GENDR-CUL	Cultural/Spiritual Aspects of Health
GB-N	Nutrition	GENDR-DP	Disease Process
GB-P	Prevention	GENDR-FU	Follow-up
GB-PM	Pain Management	GENDR-HELP	Help Line
GB-PRO	Procedures	GENDR-HPDP	Health Promotion, Disease Prevention
GB-TE	Tests	GENDR-L	Literature
GB-TX	Treatment	GENDR-LA	Lifestyle Adaptations
		GENDR-M	Medications
GE	GASTROENTERITIS	GENDR-PSY	Psychotherapy
GE-AP	Anatomy and Physiology	GENDR-S	Safety
GE-C	Complications	GENDR-SM	Stress Management
GE-CUL	Cultural/Spiritual Aspects of Health	GENDR-TLH	Tele-Health
GE-DP	Disease Process	GENDR-TX	Treatment
GE-FU	Follow-up		
GE-HM	Home Management		
GE-L	Literature		
GE-M	Medications		
GE-MNT	Medical Nutrition Therapy		
GE-N	Nutrition		
GE-PM	Pain Management		
GE-TE	Tests		
GE-TX	Treatment		

INDEX OF PATIENT EDUCATION PROTOCOLS

GAD GENERALIZED ANXIETY DISORDER

GAD-C	Complications
GAD-CM	Case Management
GAD-CUL	Cultural/Spiritual Aspects of Health
GAD-DP	Disease Process
GAD-EX	Exercise
GAD-FU	Follow-up
GAD-HELP	Help Line
GAD-HPDP	Health Promotion, Disease Prevention
GAD-IR	Information and Referral
GAD-L	Literature
GAD-LA	Lifestyle Adaptations
GAD-M	Medications
GAD-PSY	Psychotherapy
GAD-SM	Stress Management
GAD-TLH	Tele-Health
GAD-TX	Treatment

GENE GENETIC DISORDERS

GENE-AP	Anatomy and Physiology
GENE-BH	Behavioral and Emotional Health
GENE-C	Complications
GENE-CM	Case Management
GENE-DP	Disease Process
GENE-EQ	Equipment
GENE-FU	Follow-up
GENE-HM	Home Management
GENE-L	Literature
GENE-LA	Lifestyle Adaptations
GENE-M	Medications
GENE-MNT	Medical Nutrition Therapy
GENE-N	Nutrition
GENE-P	Prevention
GENE-PA	Parenting
GENE-PCC	Pre-Conception Care
GENE-PT	Physical Therapy
GENE-S	Safety
GENE-SM	Stress Management
GENE-TE	Tests

GDM GESTATIONAL DIABETES

GDM-AP	Anatomy and Physiology
GDM-BH	Behavioral and Emotional Health
GDM-C	Complications
GDM-CM	Case Management
GDM-DP	Disease Process
GDM-EX	Exercise
GDM-FU	Follow-up
GDM-L	Literature
GDM-LA	Lifestyle Adaptations
GDM-M	Medications
GDM-MNT	Medical Nutrition Therapy
GDM-N	Nutrition
GDM-SM	Stress Management
GDM-TE	Tests

GIB GI BLEED

GIB-AP	Anatomy and Physiology
GIB-C	Complications
GIB-CUL	Cultural/Spiritual Aspects of Health
GIB-DP	Disease Process
GIB-EQ	Equipment
GIB-FU	Follow-up
GIB-L	Literature
GIB-M	Medications
GIB-MNT	Medical Nutrition Therapy
GIB-N	Nutrition
GIB-P	Prevention
GIB-PRO	Procedures
GIB-SM	Stress Management
GIB-TE	Tests
GIB-TX	Treatment

GL GLAUCOMA

GL-AP	Anatomy and Physiology
GL-C	Complications
GL-DP	Disease Process
GL-FU	Follow-up
GL-HELP	Help Line
GL-L	Literature
GL-LT	Laser Therapy
GL-M	Medications
GL-PRO	Procedure
GL-TE	Tests
GL-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

GOUT GOUT (INFLAMMATORY ARTHRITIS)

GOUT-AP	Anatomy and Physiology
GOUT-C	Complications
GOUT-CUL	Cultural/Spiritual Aspects of Health
GOUT-DP	Disease Process
GOUT-EX	Exercise
GOUT-FU	Follow-up
GOUT-HM	Home Management
GOUT-HPDP	Health Promotion, Disease Prevention
GOUT-L	Literature
GOUT-LA	Lifestyle Adaptations
GOUT-M	Medications
GOUT-MNT	Medical Nutrition Therapy
GOUT-N	Nutrition
GOUT-P	Prevention
GOUT-PM	Pain Management
GOUT-PRO	Procedures
GOUT-S	Safety
GOUT-TE	Tests
GOUT-TX	Treatment
GOUT-WC	Wound Care

GRIEF GRIEF

GRIEF-BH	Behavioral and Emotional Health
GRIEF-C	Complications
GRIEF-CM	Case Management
GRIEF-CUL	Cultural/Spiritual Aspects of Health
GRIEF-EX	Exercise
GRIEF-FU	Follow-up
GRIEF-HPDP	Health Promotion, Disease Prevention
GRIEF-IR	Information and Referral
GRIEF-L	Literature
GRIEF-M	Medications
GRIEF-PSY	Psychotherapy
GRIEF-SM	Stress Management
GRIEF-TLH	Tele-Health
GRIEF-TX	Treatment

GBS GUILLAIN-BARRE SYNDROME

GBS-AP	Anatomy and Physiology
GBS-BH	Behavioral and Emotional Health
GBS-C	Complications
GBS-CM	Case Management
GBS-DP	Disease Process
GBS-EQ	Equipment
GBS-FU	Follow-up
GBS-HELP	Help Line
GBS-L	Literature
GBS-LA	Lifestyle Adaptations
GBS-M	Medications
GBS-MNT	Medical Nutrition Therapy
GBS-N	Nutrition
GBS-PM	Pain Management
GBS-S	Safety
GBS-SM	Stress Management
GBS-TE	Tests
GBS-TX	Treatment

HPS HANTAVIRUS PULMONARY SYNDROME

HPS-C	Complications
HPS-DP	Disease Process
HPS-EQ	Equipment
HPS-FU	Follow-up
HPS-HPDP	Health Promotion, Disease Prevention
HPS-L	Literature
HPS-MNT	Medical Nutrition Therapy
HPS-P	Prevention
HPS-PRO	Procedure
HPS-TE	Tests
HPS-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

LICE	HEAD LICE	HPDP	HEALTH PROMOTION, DISEASE PREVENTION
LICE-BH	Behavioral and Emotional Health	HPDP-BH	Behavioral and Emotional Health
LICE-C	Complications	HPDP-ADL	Activities of Daily Living
LICE-CM	Case Management	HPDP-CAR	Automobile Safety
LICE-DP	Disease Process	HPDP-CUL	Cultural/Spiritual Aspects of Health
LICE-FU	Follow-up	HPDP-EX	Exercise
LICE-HM	Home Management	HPDP-FU	Follow-up
LICE-HY	Hygiene	HPDP-HY	Hygiene
LICE-L	Literature	HPDP-IR	Information and Referral
LICE-M	Medications	HPDP-L	Literature
LICE-P	Prevention	HPDP-LA	Lifestyle Adaptations
LICE-TX	Treatment	HPDP-M	Medications
HA	HEADACHES	HPDP-N	Nutrition
HA-AP	Anatomy and Physiology	HPDP-PCC	Pre-Conception Care
HA-BH	Behavioral and Emotional Health	HPDP-S	Safety
HA-C	Complications	HPDP-SCR	Screening
HA-DP	Disease Process	HPDP-SM	Stress Management
HA-FU	Follow-up	HPDP-SX	Sexuality
HA-EX	Exercise	HRA	HEARING AIDS
HA-HELP	Help Line	HRA-AP	Anatomy and Physiology
HA-L	Literature	HRA-BH	Behavioral and Emotional Health
HA-LA	Lifestyle Adaptations	HRA-EQ	Equipment
HA-M	Medications	HRA-FU	Follow-up
HA-MNT	Medical Nutrition Therapy	HRA-HY	Hygiene
HA-N	Nutrition	HRA-L	Literature
HA-P	Prevention	HRA-LA	Lifestyle Adaptations
HA-PM	Pain Management	HRA-S	Safety
HA-SM	Stress Management	HRA-SM	Stress Management
HA-TE	Tests		
HA-TX	Treatment		

INDEX OF PATIENT EDUCATION PROTOCOLS

HL	HEARING LOSS	HEAT	HEATSTROKE
HL-AP	Anatomy and Physiology	HEAT-C	Complications
HL-BH	Behavioral and Emotional Health	HEAT-CUL	Cultural/Spiritual Aspects of Health
HL-C	Complications	HEAT-DP	Disease Process
HL-DP	Disease Process	HEAT-EX	Exercise
HL-EQ	Equipment	HEAT-FU	Follow-up
HL-FU	Follow-up	HEAT-L	Literature
HL-HELP	Help Line	HEAT-M	Medications
HL-L	Literature	HEAT-MNT	Medical Nutrition Therapy
HL-LA	Lifestyle Adaptations	HEAT-N	Nutrition
HL-P	Prevention	HEAT-P	Prevention
HL-PRO	Procedures	HEAT-S	Safety
HL-S	Safety	HEAT-TE	Tests
HL-SCR	Screening	HEAT-TX	Treatment
HL-TE	Tests		
HL-TX	Treatment		
HF	HEART FAILURE	HEM	HEMORRHOIDS
HF-ADV	Advance Directive	HEM-AP	Anatomy and Physiology
HF-AP	Anatomy and Physiology	HEM-C	Complications
HF-BH	Behavioral and Emotional Health	HEM-CUL	Cultural/Spiritual Aspects of Health
HF-C	Complications	HEM-DP	Disease Process
HF-CM	Case Management	HEM-EX	Exercise
HF-CUL	Cultural/Spiritual Aspects of Health	HEM-FU	Follow-up
HF-DCHL	Discharge Literature	HEM-HM	Home Management
HF-DP	Disease Process	HEM-HPDP	Health Promotion, Disease Prevention
HF-EQ	Equipment	HEM-HY	Hygiene
HF-EX	Exercise	HEM-L	Literature
HF-FU	Follow-up	HEM-LA	Lifestyle Adaptations
HF-HELP	Help Line	HEM-M	Medications
HF-HM	Home Management	HEM-MNT	Medical Nutrition Therapy
HF-L	Literature	HEM-N	Nutrition
HF-LA	Lifestyle Adaptations	HEM-P	Prevention
HF-M	Medications	HEM-PM	Pain Management
HF-MNT	Medical Nutrition Therapy	HEM-PRO	Procedure
HF-N	Nutrition	HEM-SM	Stress Management
HF-P	Prevention	HEP-TE	Tests
HF-PRO	Procedure	HEP-TX	Treatment
HF-SHS	Second-Hand/Third-Hand Smoke		
HF-SM	Stress Management		
HF-TE	Tests		
HF-TLH	Tele-Health		
HF-TO	Tobacco		
HF-TX	Treatment		

INDEX OF PATIENT EDUCATION PROTOCOLS

HEP	HEPATITIS A,B,C	IV	HOME IV THERAPY
HEP-AP	Anatomy and Physiology	IV-AP	Anatomy and Physiology
HEP-BH	Behavioral and Emotional Health	IV-C	Complications
HEP-C	Complications	IV-CM	Case Management
HEP-CM	Case Management	IV-CUL	Cultural/Spiritual Aspects of Health
HEP-CUL	Cultural/Spiritual Aspects of Health	IV-EQ	Equipment
HEP-DPA	Disease Process Hepatitis A	IV-FU	Follow-up
HEP-DPB	Disease Process Hepatitis B	IV-HM	Home Management
HEP-DPC	Disease Process Hepatitis C	IV-HPDP	Health Promotion, Disease Prevention
HEP-FU	Follow-up	IV-HY	Hygiene
HEP-HELP	Help Line	IV-L	Literature
HEP-HM	Home Management	IV-LA	Lifestyle Adaptations
HEP-HPDP	Health Promotion, Disease Prevention	IV-M	Medications
HEP-HY	Hygiene	IV-MNT	Medical Nutrition Therapy
HEP-L	Literature	IV-PM	Pain Management
HEP-LA	Lifestyle Adaptations	IV-PRO	Procedure
HEP-M	Medications	IV-S	Safety
HEP-MNT	Medical Nutrition Therapy	IV-SM	Stress Management
HEP-N	Nutrition	IV-TE	Tests
HEP-P	Prevention	IV-TLH	Tele-Health
HEP-PCC	Pre-Conception Care	IV-TX	Treatment
HEP-PRO	Procedure	IV-WC	Wound Care
HEP-TE	Tests		
HEP-TX	Treatment		

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HIV	HUMAN IMMUNODEFICIENCY VIRUS	LIP	HYPERLIPIDEMIA / DYSLIPIDEMIAS
HIV-ADV	Advance Directive	LIP-AP	Anatomy and Physiology
HIV-BH	Behavioral and Emotional Health	LIP-C	Complications
HIV-C	Complications	LIP-CM	Case Management
HIV-CM	Case Management	LIP-CUL	Cultural/Spiritual Aspects of Health
HIV-CUL	Cultural/Spiritual Aspects of Health	LIP-DP	Disease Process
HIV-DP	Disease Process	LIP-EX	Exercise
HIV-EQ	Equipment	LIP-FU	Follow-up
HIV-FU	Follow-up	LIP-HM	Home Management
HIV-HELP	Help Line	LIP-HPDP	Health Promotion, Disease Prevention
HIV-HM	Home Management	LIP-L	Literature
HIV-HPDP	Health Promotion, Disease Prevention	LIP-LA	Lifestyle Adaptations
HIV-HY	Hygiene	LIP-M	Medications
HIV-L	Literature	LIP-MNT	Medical Nutrition Therapy
HIV-LA	Lifestyle Adaptations	LIP-N	Nutrition
HIV-M	Medications	LIP-P	Prevention
HIV-MNT	Medical Nutrition Therapy	LIP-SM	Stress Management
HIV-N	Nutrition	LIP-TE	Tests
HIV-P	Prevention	LIP-TLH	Tele-Health
HIV-PCC	Pre-Conception Care	LIP-TX	Treatment
HIV-PN	Prenatal		
HIV-S	Safety		
HIV-SM	Stress Management		
HIV-TE	Tests		
HIV-TX	Treatment		

INDEX OF PATIENT EDUCATION PROTOCOLS

HTN	HYPERTENSION	HPTH	HYPOTHERMIA
HTN-AP	Anatomy and Physiology	HPTH-C	Complications
HTN-BH	Behavioral and Emotional Health	HPTH-CUL	Cultural/Spiritual Aspects of Health
HTN-C	Complications	HPTH-DP	Disease Process
HTN-CUL	Cultural/Spiritual Aspects of Health	HPTH-EQ	Equipment
HTN-DP	Disease Process	HPTH-FU	Follow-up
HTN-EQ	Equipment	HPTH-L	Literature
HTN-EX	Exercise	HPTH-M	Medications
HTN-FU	Follow-up	HPTH-MNT	Medical Nutrition Therapy
HTN-HELP	Help Line	HPTH-N	Nutrition
HTN-L	Literature	HPTH-P	Prevention
HTN-LA	Lifestyle Adaptations	HPTH-PM	Pain Management
HTN-M	Medications	HPTH-SM	Stress Management
HTN-MNT	Medical Nutrition Therapy	HPTH-TE	Tests
HTN-N	Nutrition	HPTH-TX	Treatment
HTN-PCC	Pre-Conception Care		
HTN-SHS	Second-Hand/Third-Hand Smoke	LTH	HYPOTHYROIDISM
HTH-SCR	Screening	LTH-AP	Anatomy and Physiology
HTH-SM	Stress Management	LTH-C	Complications
HTN-TE	Tests	LTH-DP	Disease Process
HTN-TLH	Tele-Health	LTH-EX	Exercise
HTN-TX	Treatment	LTH-FU	Follow-up
		LTH-HELP	Help Line
HTH	HYPERTHYROIDISM	LTH-L	Literature
HTH-AP	Anatomy and Physiology	LTH-LA	Lifestyle Adaptations
HTH-C	Complications	LTH-M	Medications
HTH-CUL	Cultural/Spiritual Aspects of Health	LTH-MNT	Medical Nutrition Therapy
HTH-DP	Disease Process	LTH-N	Nutrition
HTH-FU	Follow-up	LTH-PCC	Pre-Conception Care
HTH-HELP	Help Line	LTH-TE	Tests
HTH-L	Literature		
HTH-M	Medications		
HTH-MNT	Medical Nutrition Therapy		
HTH-N	Nutrition		
HTN-PCC	Pre-Conception Care		
HTH-TE	Tests		
HTH-TX	Treatment		

INDEX OF PATIENT EDUCATION PROTOCOLS

IM IMMUNIZATIONS

IM-C	Complications
IM-DEF	Deficiency
IM-FU	Follow-up
IM-I	Immunization Information
IM-L	Literature
IM-P	Prevention
IM-SCH	Schedule

IMP IMPETIGO

IMP-C	Complications
IMP-DP	Disease Process
IMP-FU	Follow-up
IMP-HY	Hygiene
IMP-L	Literature
IMP-M	Medications
IMP-P	Prevention
IMP-TX	Treatment
IMP-WC	Wound Care

IMPLS IMPULSE CONTROL DISORDERS

IMPLS-C	Complications
IMPLS-CM	Case Management
IMPLS-CUL	Cultural/Spiritual Aspects of Health
IMPLS-DP	Disease Process
IMPLS-EX	Exercise
IMPLS-FU	Follow-up
IMPLS-HELP	Help Line
IMPLS-HPDP	Health Promotion, Disease Prevention
IMPLS-L	Literature
IMPLS-LA	Lifestyle Adaptations
IMPLS-M	Medications
IMPLS-MNT	Medical Nutrition Therapy
IMPLS-N	Nutrition
IMPLS-PSY	Psychotherapy
IMPLS-S	Safety
IMPLS-SM	Stress Management
IMPLS-TLH	Tele-Health
IMPLS-TX	Treatment

FLU INFLUENZA

FLU-AP	Anatomy and Physiology
FLU-C	Complications
FLU-CM	Case Management
FLU-CUL	Cultural/Spiritual Aspects of Health
FLU-DP	Disease Process
FLU-FU	Follow-up
FLU-HM	Home Management
FLU-HPDP	Health Promotion, Disease Prevention
FLU-L	Literature
FLU-M	Medications
FLU-MNT	Medical Nutrition Therapy
FLU-N	Nutrition
FLU-P	Prevention
FLU-PM	Pain Management
FLU-TE	Tests
FLU-TX	Treatment

INJ INJURIES

INJ-AP	Anatomy and Physiology
INJ-BH	Behavioral and Emotional Health
INJ-CC	Cast Care
INJ-EQ	Equipment
INJ-EX	Exercise
INJ-FU	Follow-up
INJ-HM	Home Management
INJ-I	Information
INJ-L	Literature
INJ-M	Medications
INJ-MNT	Medical Nutrition Therapy
INJ-P	Prevention
INJ-PM	Pain Management
INJ-TE	Tests
INJ-TX	Treatment
INJ-WC	Wound Care

INDEX OF PATIENT EDUCATION PROTOCOLS

JRA JUVENILE RHEUMATOID ARTHRITIS

JRA-AP	Anatomy and Physiology
JRA-BH	Behavioral and Emotional Health
JRA-C	Complications
JRA-CM	Case Management
JRA-CUL	Cultural/Spiritual Aspects of Health
JRA-DP	Disease Process
JRA-EQ	Equipment
JRA-EX	Exercise
JRA-FU	Follow-up
JRA-HELP	Help Line
JRA-HPDP	Health Promotion, Disease Prevention
JRA-HY	Hygiene
JRA-L	Literature
JRA-LA	Lifestyle Adaptations
JRA-M	Medications
JRA-MNT	Medical Nutrition Therapy
JRA-N	Nutrition
JRA-PM	Pain Management
JRA-PRO	Procedure
JRA-PT	Physical Therapy
JRA-S	Safety
JRA-SM	Stress Management
JRA-TE	Tests
JRA-TLH	Tele-Health
JRA-TX	Treatment

STONES KIDNEY STONES

STONES-AP	Anatomy and Physiology
STONES-C	Complications
STONES-DP	Disease Process
STONES-EQ	Equipment
STONES-FU	Follow-up
STONES-HELP	Help Line
STONES-HM	Home Management
STONES-L	Literature
STONES-M	Medications
STONES-MNT	Medical Nutrition Therapy
STONES-N	Nutrition
STONES-P	Prevention
STONES-PM	Pain Management
STONES-PRO	Procedure
STONES-TE	Tests
STONES-TX	Treatment

LAB LABORATORY

LAB-DRAW	Phlebotomy
LAB-FU	Follow-up
LAB-L	Literature
LAB-S	Safety
LAB-TE	Tests

LEAD LEAD EXPOSURE/ LEAD TOXICITY

LEAD-AP	Anatomy and Physiology
LEAD-BH	Behavioral and Emotional Health
LEAD-C	Complications
LEAD-DP	Disease Process
LEAD-FU	Follow-up
LEAD-HELP	Help Line
LEAD-HM	Home Management
LEAD-HY	Hygiene
LEAD-L	Literature
LEAD-MNT	Medical Nutrition Therapy
LEAD-N	Nutrition
LEAD-P	Prevention
LEAD-SCR	Screening
LEAD-TE	Tests
LEAD-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

LD	LEARNING DISORDERS/ DISABILITIES	LIV	LIVER DISEASE
LD-BH	Behavioral and Emotional Health	LIV-ADV	Advance Directive
LD-C	Complications	LIV-AP	Anatomy and Physiology
LD-CM	Case Management	LIV-BH	Behavioral and Emotional Health
LD-CUL	Cultural/Spiritual Aspects of Health	LIV-C	Complications
LD-DP	Disease Process	LIV-CM	Case Management
LD-EX	Exercise	LIV-CUL	Cultural/Spiritual Aspects of Health
LD-FU	Follow-up	LIV-DP	Disease Process
LD-HELP	Help Line	LIV-FU	Follow-up
LD-HPDP	Health Promotion, Disease Prevention	LIV-HELP	Help Line
LD-IR	Information and Referral	LIV-HPDP	Health Promotion, Disease Prevention
LD-L	Literature	LIV-HY	Hygiene
LD-LA	Lifestyle Adaptations	LIV-L	Literature
LD-M	Medications	LIV-LA	Lifestyle Adaptations
LD-N	Nutrition	LIV-M	Medications
LD-PSY	Psychotherapy	LIV-MNT	Medical Nutrition Therapy
LD-SM	Stress Management	LIV-N	Nutrition
LD-TE	Tests	LIV-P	Prevention
LD-TLH	Tele-Health	LIV-PCC	Pre-Conception Care
LD-TX	Treatment	LIV-TE	Tests
		LIV-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

LOMA LYMPHOMA

LOMA-ADV	Advance Directive
LOMA-AP	Anatomy and Physiology
LOMA-BH	Behavioral and Emotional Health
LOMA-C	Complications
LOMA-CA	Case Management
LOMA-CUL	Cultural/Spiritual Aspects of Health
LOMA-DP	Disease Process
LOMA-EQ	Equipment
LOMA-EX	Exercise
LOMA-FU	Follow-up
LOMA-HELP	Help Line
LOMA-HM	Home Management
LOMA-HPDP	Health Promotion, Disease Prevention
LOMA-HY	Hygiene
LOMA-L	Literature
LOMA-LA	Lifestyle Adaptations
LOMA-M	Medications
LOMA-MNT	Medical Nutrition Therapy
LOMA-N	Nutrition
LOMA-P	Prevention
LOMA-PCC	Pre-Conception Care
LOMA-PM	Pain Management
LOMA-PRO	Procedure
LOMA-SHS	Second-Hand/Third-Hand Smoke
LOMA-SM	Stress Management
LOMA-TE	Tests
LOMA-TLH	Tele-Health
LOMA-TX	Treatment
LOMA-WC	Wound Care

LYME LYME DISEASE

LYME-C	Complications
LYME-DP	Disease Process
LYME-FU	Follow-up
LYME-HELP	Help Line
LYME-L	Literature
LYME-M	Medications
LYME-MNT	Medical Nutrition Therapy
LYME-P	Prevention
LYME-TE	Tests
LYME-TLH	Tele-Health
LYME-TX	Treatment

MSAF MEDICAL SAFETY

MSAF-C	Complications
MSAF-FU	Follow-up
MSAF-HY	Hygiene
MSAF-I	Information
MSAF-L	Literature
MSAF-M	Medications
MSAF-P	Prevention
MSAF-PRO	Procedure
MSAF-TE	Tests

M MEDICATIONS

M-ADD	Addiction
M-DI	Drug Interaction
M-FU	Follow-up
M-I	Information
M-L	Literature
M-MB	Medication Box Teaching
M-MDI	Metered-Dose Inhaler
M-MR	Medication Reconciliation
M-NEB	Nebulizer
M-TE	Tests

INDEX OF PATIENT EDUCATION PROTOCOLS

MNG	MENINGITIS	MH	MEN'S HEALTH
MNG-ADV	Advance Directive	MH-AP	Anatomy and Physiology
MNG-AP	Anatomy and Physiology	MH-BE	Breast Exam
MNG-BH	Behavioral and Emotional Health	MH-CRC	Colorectal Cancer Screening
MNG-C	Complications	MH-CUL	Cultural/Spiritual Aspects of Health
MNG-CA	Case Management		
MNG-CUL	Cultural/Spiritual Aspects of Health	MH-EX	Exercise
		MH-FU	Follow-up
MNG-DP	Disease Process	MH-HY	Hygiene
MNG-EQ	Equipment	MH-IM	Immunizations
MNG-EX	Exercise	MH-L	Literature
MNG-FU	Follow-up	MH-M	Medications
MNG-HELP	Help Line	MH-MNT	Medical Nutrition Therapy
MNG-HM	Home Management	MH-N	Nutrition
MNG-HPDP	Health Promotion, Disease Prevention	MH-PCC	Pre-Conception Care
		MH-PRS	Prostate Health
MNG-HY	Hygiene	MH-SM	Stress Management
MNG-L	Literature	MH-SX	Sexuality
MNG-LA	Lifestyle Adaptations	MH-TE	Tests
MNG-M	Medications	MH-TSE	Testicular Self-Exam
MNG-MNT	Medical Nutrition Therapy		
MNG-N	Nutrition	MPS	MENOPAUSE
MNG-P	Prevention	MPS-AP	Anatomy and Physiology
MNG-PM	Pain Management	MPS-BH	Behavioral and Emotional Health
MNG-PRO	Procedure	MPS-C	Complications
MNG-PSY	Psychotherapy	MPS-CUL	Cultural/Spiritual Aspects of Health
MNG-S	Safety		
MNG-SM	Stress Management	MPS-DP	Disease Process
MNG-TE	Tests	MPS-EX	Exercise
MNG-TLH	Tele-Health	MPS-FU	Follow-up
MNG-TX	Treatment	MPS-HELP	Help Line
		MPS-HPDP	Health Promotion, Disease Prevention
		MPS-L	Literature
		MPS-LA	Lifestyle Adaptations
		MPS-M	Medications
		MPS-MNT	Medical Nutrition Therapy
		MPS-N	Nutrition
		MPS-PRO	Procedures
		MPS-S	Safety
		MPS-SM	Stress Management
		MPS-TE	Tests

INDEX OF PATIENT EDUCATION PROTOCOLS

MNTL MENTAL HEALTH

MNTL-AM	Anger Management
MNTL-AS	Assertiveness Skills
MNTL-CD	Cognitive Distortions
MNTL-COM	Communication Skills
MNTL-COP	Coping Skills
MNTL-CR	Conflict Resolution
MNTL-DEF	Defenses/Resistance
MNTL-FI	Feeling Identification
MNTL-GP	Grieving Process
MNTL-HPDP	Health Promotion, Disease Prevention
MNTL-L	Literature
MNTL-PA	Parenting
MNTL-PSY	Psychotherapy
MNTL-REL	Interpersonal Relationships
MNTL-SM	Stress Management

MR MENTAL RETARDATION

MR-BH	Behavioral and Emotional Health
MR-C	Complications
MR-CM	Case Management
MR-CUL	Cultural/Spiritual Aspects of Health
MR-DP	Disease Process
MR-EX	Exercise
MR-FU	Follow-up
MR-HELP	Help Line
MR-HPDP	Health Promotion, Disease Prevention
MR-HY	Hygiene
MR-L	Literature
MR-LA	Lifestyle Adaptations
MR-M	Medications
MR-MNT	Medical Nutrition Therapy
MR-N	Nutrition
MH-PCC	Pre-Conception Health
MR-S	Safety
MR-SCR	Screening
MR-SM	Stress Management
MR-TE	Tests
MR-TLH	Tele-Health
MR-TX	Treatment

MSX METABOLIC SYNDROME

MSX-AP	Anatomy and Physiology
MSX-BH	Behavioral and Emotional Health
MSX-C	Complications
MSX-CM	Case Management
MSX-CUL	Cultural/Spiritual Aspects of Health
MSX-DP	Disease Process
MSX-EQ	Equipment
MSX-EX	Exercise
MSX-FU	Follow-up
MSX-HELP	Help Line
MSX-HPDP	Health Promotion, Disease Prevention
MSX-L	Literature
MSX-LA	Lifestyle Adaptations
MSX-M	Medications
MSX-MNT	Medical Nutrition Therapy
MSX-N	Nutrition
MSX-P	Prevention
MSX-PCC	Pre-Conception Care
MSX-REF	Referral
MSX-SM	Stress Management
MSX-TE	Tests
MSX-TLH	Tele-Health
MSX-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

MDRO MULTIDRUG-RESISTANT ORGANISM

MDRO-C	Complications
MDRO-CM	Case Management
MDRO-CUL	Cultural/Spiritual Aspects of Health
MDRO-DP	Disease Process
MDRO-EQ	Equipment
MDRO-FU	Follow-up
MDRO-HM	Home Management
MDRO-HPDP	Health Promotion, Disease Prevention
MDRO-HY	Hygiene
MDRO-ISO	Isolation
MDRO-L	Literature
MDRO-M	Medications
MDRO-P	Prevention
MDRO-PRO	Procedure
MDRO-TE	Tests
MDRO-TX	Treatment
MDRO-WC	Wound Care

MD MUSCULAR DYSTROPHY

MD-ADV	Advance Directive
MD-AP	Anatomy and Physiology
MD-C	Complications
MD-CA	Case Management
MD-CUL	Cultural/Spiritual Aspects of Health
MD-DP	Disease Process
MD-EQ	Equipment
MD-EX	Exercise
MD-FU	Follow-up
MD-HELP	Help Line
MD-HM	Home Management
MD-HPDP	Health Promotion, Disease Prevention
MD-HY	Hygiene
MD-L	Literature
MD-LA	Lifestyle Adaptations
MD-M	Medications
MD-MNT	Medical Nutrition Therapy
MD-N	Nutrition
MD-P	Prevention
MD-PM	Pain Management
MD-PRO	Procedure
MD-PSY	Psychotherapy
MD-S	Safety
MD-SM	Stress Management
MD-TE	Tests
MD-TLH	Tele-Health
MD-TX	Treatment
MD-WC	Wound Care

NDR NEAR DROWNING

NDR-AP	Anatomy and Physiology
NDR-BH	Behavioral and Emotional Health
NDR-C	Complications
NDR-FU	Follow-up
NDR-IR	Information and Referral
NDR-L	Literature
NDR-M	Medications
NDR-P	Prevention
NDR-TE	Tests

INDEX OF PATIENT EDUCATION PROTOCOLS

NF	NEONATAL FEVER	NOSE	NOSE BLEED (EPISTAXIS)
NF-C	Complications	NOSE-AP	Anatomy and Physiology
NF-DP	Disease Process	NOSE-C	Complications
NF-EQ	Equipment	NOSE-DP	Disease Process
NF-FU	Follow-up	NOSE-FU	Follow-up
NF-L	Literature	NOSE-HM	Home Management
NF-M	Medications	NOSE-HY	Hygiene
NF-P	Prevention	NOSE-L	Literature
NF-TE	Tests	NOSE-M	Medications
		NOSE-P	Prevention
NJ	NEONATAL JAUNDICE	NOSE-PRO	Procedures
NJ-C	Complications	NOSE-S	Safety
NJ-DP	Disease Process	NOSE-TE	Tests
NJ-P	Prevention	NOSE-TX	Treatment
NJ-TE	Tests		
NJ-TX	Treatment	OBS	OBESITY
		OBS-BH	Behavioral and Emotional Health
ND	NEUROLOGIC DISORDER	OBS-C	Complications
ND-AP	Anatomy and Physiology	OBS-CM	Case Management
ND-BH	Behavioral and Emotional Health	OBS-CUL	Cultural/Spiritual Aspects of Health
ND-CUL	Cultural/Spiritual Aspects of Health	OBS-DP	Disease Process
ND-DP	Disease Process	OBS-EX	Exercise
ND-EQ	Equipment	OBS-FU	Follow-up
ND-EX	Exercise	OBS-HELP	Help Line
ND-FU	Follow-up	OBS-IR	Information and Referral
ND-L	Literature	OBS-L	Literature
ND-LA	Lifestyle Adaptations	OBS-LA	Lifestyle Adaptations
ND-M	Medications	OBS-M	Medications
ND-MNT	Medical Nutrition Therapy	OBS-MNT	Medical Nutrition Therapy
ND-N	Nutrition	OBS-N	Nutrition
ND-PM	Pain Management	OBS-P	Prevention
ND-S	Safety	OBS-PCC	Pre-Conception Care
ND-TE	Tests	OBS-SCR	Screening
ND-TX	Treatment	OBS-SM	Stress Management
		OBS-TE	Tests

INDEX OF PATIENT EDUCATION PROTOCOLS

OBSC OBESITY IN CHILDREN (INFANCY TO 18 YEARS)

OBSC-AP	Anatomy and Physiology
OBSC-BH	Behavioral and Emotional Health
OBSC-C	Complications
OBSC-CM	Case Management
OBSC-CUL	Cultural/Spiritual Aspects of Health
OBSC-DP	Disease Process
OBSC-EX	Exercise
OBSC-FU	Follow-up
OBSC-HELP	Help Line
OBSC-HPDP	Health Promotion, Disease Prevention
OBSC-HY	Hygiene
OBSC-L	Literature
OBSC-LA	Lifestyle Adaptations
OBSC-M	Medications
OBSC-MNT	Medical Nutrition Therapy
OBSC-N	Nutrition
OBSC-SM	Stress Management
OBSC-TE	Tests
OBSC-TX	Treatment

OCD OBSESSIVE-COMPULSIVE DISORDER

OCD-C	Complications
OCD-CM	Case Management
OCD-CUL	Cultural/Spiritual Aspects of Health
OCD-DP	Disease Process
OCD-EX	Exercise
OCD-FU	Follow-up
OCD-HY	Hygiene
OCD-IR	Information and Referral
OCD-L	Literature
OCD-LA	Lifestyle Adaptations
OCD-M	Medications
OCD-PSY	Psychotherapy
OCD-S	Safety
OCD-SM	Stress Management
OCD-TLH	Tele-Health
OCD-TX	Treatment

OSA OBSTRUCTIVE SLEEP APNEA

OSA-AP	Anatomy and Physiology
OSA-C	Complications
OSA-DP	Disease Process
OSA-EQ	Equipment
OSA-FU	Follow-up
OSA-HELP	Help Line
OSA-HPDP	Health Promotion, Disease Prevention
OSA-L	Literature
OSA-LA	Lifestyle Adaptations
OSA-M	Medications
OSA-MNT	Medical Nutrition Therapy
OSA-N	Nutrition
OSA-PRO	Procedures
OSA-TE	Tests
OSA-TX	Treatment

OCCU OCCUPATIONAL HEALTH

OCCU-EQ	Equipment
OCCU-EX	Exercise
OCCU-FU	Follow-up
OCCU-HPDP	Health Promotion, Disease Prevention
OCCU-HY	Hygiene
OCCU-IM	Immunizations
OCCU-L	Literature
OCCU-LA	Lifestyle Adaptations
OCCU-M	Medications
OCCU-OR	Orientation
OCCU-P	Prevention
OCCU-PM	Pain Management
OCCU-S	Safety
OCCU-SCR	Screening
OCCU-SM	Stress Management
OCCU-TE	Tests
OCCU-TX	Treatment
OCCU-WC	Wound Care

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ODM	OCULAR DIABETES MELLITUS
ODM-AP	Anatomy and Physiology
ODM-BH	Behavioral and Emotional Health
ODM-C	Complications
ODM-CM	Case Management
ODM-DP	Disease Process
ODM-EX	Exercise
ODM-FU	Follow-up
ODM-HM	Home Management
ODM-L	Literature
ODM-LA	Lifestyle Adaptations
ODM-LT	Laser Therapy
ODM-M	Medications
ODM-PM	Pain Management
ODM-PRO	Procedure
ODM-S	Safety
ODM-TE	Tests
ODM-TLH	Tele-Health
ODM-TX	Treatment

ODD OPPOSITIONAL DEFIANT DISORDER

ODD-C	Complications
ODD-CM	Case Management
ODD-CUL	Cultural/Spiritual Aspects of Health
ODD-DP	Disease Process
ODD-EX	Exercise
ODD-FU	Follow-up
ODD-HPDP	Health Promotion, Disease Prevention
ODD-IR	Information and Referral
ODD-L	Literature
ODD-LA	Lifestyle Adaptations
ODD-M	Medications
ODD-PA	Parenting
ODD-PSY	Psychotherapy
ODD-S	Safety
ODD-SM	Stress Management
ODD-TLH	Tele-Health
ODD-TX	Treatment

TPLNT	ORGAN DONATION/ TRANSPLANT
TPLNT-AP	Anatomy and Physiology
TPLNT-BH	Behavioral and Emotional Health
TPLNT-C	Complications
TPLNT-CM	Case Management
TPLNT-CUL	Cultural/Spiritual Aspects of Health
TPLNT-FU	Follow-up
TPLNT-HELP	Help Line
TPLNT-HPDP	Health Promotion, Disease Prevention
TPLNT-HY	Hygiene
TPLNT-L	Literature
TPLNT-LA	Lifestyle Adaptations
TPLNT-M	Medications
TPLNT-MNT	Medical Nutrition Therapy
TPLNT-N	Nutrition
TPLNT-PCC	Pre-Conception Care
TPLNT-PM	Pain Management
TPLNT-PRO	Procedure
TPLNT-S	Safety
TPLNT-TE	Tests
TPLNT-TLH	Tele-Health
TPLNT-TX	Treatment
TPLNT-WC	Wound Care

ORTH ORTHOPEDICS

ORTH-AP	Anatomy and Physiology
ORTH-C	Complications
ORTH-CC	Cast Care
ORTH-DP	Disease Process
ORTH-EQ	Equipment
ORTH-FU	Follow-up
ORTH-L	Literature
ORTH-M	Medications
ORTH-MNT	Medical Nutrition Therapy
ORTH-N	Nutrition
ORTH-P	Prevention
ORTH-PM	Pain Management
ORTH-PRO	Procedures
ORTH-PT	Physical Therapy
ORTH-S	Safety
ORTH-TE	Tests
ORTH-TX	Treatment
ORTH-WC	Wound Care

INDEX OF PATIENT EDUCATION PROTOCOLS

OA	OSTEOARTHRITIS	OS	OSTEOPOROSIS
OA-AP	Anatomy and Physiology	OS-AP	Anatomy and Physiology
OA-BH	Behavioral and Emotional Health	OS-BH	Behavioral and Emotional Health
OA-C	Complications	OS-C	Complications
OA-CM	Case Management	OS-CUL	Cultural/Spiritual Aspects of Health
OA-CUL	Cultural/Spiritual Aspects of Health	OS-DP	Disease Process
OA-DP	Disease Process	OS-EQ	Equipment
OA-EQ	Equipment	OS-EX	Exercise
OA-EX	Exercise	OS-FU	Follow-up
OA-FU	Follow-up	OS-HELP	Help Line
OA-HELP	Help Line	OS-HM	Home Management
OA-HM	Home Management	OS-L	Literature
OA-HPDP	Health Promotion, Disease Prevention	OS-M	Medications
OA-HY	Hygiene	OS-MNT	Medical Nutrition Therapy
OA-L	Literature	OS-N	Nutrition
OA-LA	Lifestyle Adaptations	OS-P	Prevention
OA-M	Medications	OS-PM	Pain Management
OA-MNT	Medical Nutrition Therapy	OS-TE	Tests
OA-N	Nutrition	OS-TX	Treatment
OA-PM	Pain Management	OST	OSTOMY
OA-PRO	Procedures	OST-AP	Anatomy and Physiology
OA-PT	Physical Therapy	OST-BH	Behavioral and Emotional Health
OA-S	Safety	OST-C	Complications
OA-SM	Stress Management	OST-DP	Disease Process
OA-TE	Test	OST-EQ	Equipment
OA-TX	Treatment	OST-EX	Exercise
		OST-FU	Follow-up
		OST-HELP	Help Line
		OST-HM	Home Management
		OST-L	Literature
		OST-LA	Lifestyle Adaptations
		OST-M	Medications
		OST-MNT	Medical Nutrition Therapy
		OST-N	Nutrition
		OST-SM	Stress Management
		OST-WC	Wound Care

INDEX OF PATIENT EDUCATION PROTOCOLS

OEX	OTITIS EXTERNA	PM	PAIN MANAGEMENT
OEX-AP	Anatomy and Physiology	PM-AP	Anatomy and Physiology
OEX-C	Complications	PM-BH	Behavioral and Emotional Health
OEX-DP	Disease Process	PM-CM	Case Management
OEX-FU	Follow-up	PM-CUL	Cultural/Spiritual Aspects of Health
OEX-L	Literature		
OEX-M	Medications	PM-DP	Disease Process
OEX-P	Prevention	PM-EQ	Equipment
OEX-PM	Pain Management	PM-EX	Exercise
OEX-PRO	Procedure	PM-FU	Follow-up
OEX-TE	Tests	PM-HPDP	Health Promotion, Disease Prevention
OEX-TX	Treatment		
OM	OTITIS MEDIA	PM-L	Literature
OM-AP	Anatomy and Physiology	PM-LA	Lifestyle Adaptations
OM-C	Complications	PM-M	Medications
OM-DP	Disease Process	PM-MNT	Medical Nutrition Therapy
OM-FU	Follow-up	PM-N	Nutrition
OM-HM	Home Management	PM-P	Prevention
OM-L	Literature	PM-PSY	Psychotherapy
OM-LA	Lifestyle Adaptations	PM-S	Safety
OM-M	Medications	PM-TE	Tests
OM-P	Prevention	PM-TX	Treatment
OM-PET	Pressure Equalization Tubes	PC	PANCREATITIS
OM-PM	Pain Management	PC-AP	Anatomy and Physiology
OM-PRO	Procedure	PC-C	Complications
OM-REF	Referral	PC-CUL	Cultural/Spiritual Aspects of Health
OM-SHS	Second-Hand/Third-Hand Smoke		
OM-TE	Tests	PC-DP	Disease Process
OM-TX	Treatment	PC-FU	Follow-up
		PC-HELP	Help Line
		PC-L	Literature
		PC-LA	Lifestyle Adaptations
		PC-M	Medications
		PC-MNT	Medical Nutrition Therapy
		PC-N	Nutrition
		PC-P	Prevention
		PC-PM	Pain Management
		PC-PRO	Procedures
		PC-TE	Tests
		PC-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

PANIC PANIC DISORDER

PANIC-C	Complications
PANIC-CM	Case Management
PANIC-CUL	Cultural/Spiritual Aspects of Health
PANIC-DP	Disease Process
PANIC-EX	Exercise
PANIC-FU	Follow-up
PANIC-IR	Information and Referral
PANIC-L	Literature
PANIC-M	Medications
PANIC-PSY	Psychotherapy
PANIC-SM	Stress Management
PANIC-TLH	Tele-Health
PANIC-TX	Treatment

PRK PARKINSON DISEASE

PRK-AP	Anatomy and Physiology
PRK-BH	Behavioral and Emotional Health
PRK-C	Complications
PRK-CM	Case Management
PRK-DP	Disease Process
PRK-EQ	Equipment
PRK-EX	Exercise
PRK-FU	Follow-up
PRK-HELP	Help Line
PRK-HPDP	Health Promotion, Disease Prevention
PRK-HY	Hygiene
PRK-L	Literature
PRK-LA	Lifestyle Adaptations
PRK-M	Medications
PRK-MNT	Medical Nutrition Therapy
PRK-N	Nutrition
PRK-PRO	Procedure
PRK-SM	Stress Management
PRK-TE	Tests
PRK-TX	Treatment

PNL PERINATAL LOSS

PNL-BH	Behavioral and Emotional Health
PNL-C	Complications
PNL-CUL	Cultural/Spiritual Aspects of Health
PNL-DP	Disease Process
PNL-FU	Follow-up
PNL-GP	Grieving Process
PNL-HPDP	Health Promotion, Disease Prevention
PNL-IR	Information and Referral
PNL-L	Literature
PNL-M	Medications
PNL-MNT	Medical Nutrition Therapy
PNL-N	Nutrition
PNL-PM	Pain Management
PNL-SM	Stress Management
PNL-TX	Treatment

PERIO PERIODONTAL DISEASE

PERIO-AP	Anatomy and Physiology
PERIO-C	Complications
PERIO-DP	Disease Process
PERIO-FU	Follow-up
PERIO-HPDP	Health Promotion, Disease Prevention
PERIO-HY	Hygiene
PERIO-L	Literature
PERIO-M	Medications
PERIO-N	Nutrition
PERIO-P	Prevention
PERIO-PM	Pain Management
PERIO-PRO	Procedures
PERIO-TE	Tests
PERIO-TO	Tobacco
PERIO-TX	Treatment
PERIO-WC	Wound Care

INDEX OF PATIENT EDUCATION PROTOCOLS

PVD PERIPHERAL VASCULAR DISEASE

PVD-ADV	Advance Directive
PVD-AP	Anatomy and Physiology
PVD-BH	Behavioral and Emotional Health
PVD-C	Complications
PVD-CM	Case Management
PVD-CUL	Cultural/Spiritual Aspects of Health
PVD-DP	Disease Process
PVD-EX	Exercise
PVD-FU	Follow-up
PVD-HELP	Help Line
PVD-HM	Home Management
PVD-HPDP	Health Promotion, Disease Prevention
PVD-L	Literature
PVD-LA	Lifestyle Adaptations
PVD-M	Medications
PVD-MNT	Medical Nutrition Therapy
PVD-N	Nutrition
PVD-P	Prevention
PVD-PM	Pain Management
PVD-PRO	Procedure
PVD-REF	Referral
PVD-SCR	Screening
PVD-SHS	Second-Hand/Third-Hand Smoke
PVD-TE	Tests
PVD-TX	Treatment
PCD-WC	Wound Care

PERSD PERSONALITY DISORDER

PERSD-C	Complications
PERSD-CM	Case Management
PERSD-CUL	Cultural/Spiritual Aspects of Health
PERSD-DP	Disease Process
PERSD-EX	Exercise
PERSD-FU	Follow-up
PERSD-HPDP	Health Promotion, Disease Prevention
PERSD-IR	Information and Referral
PERSD-L	Literature
PERSD-LA	Lifestyle Adaptations
PERSD-M	Medications
PERSD-PSY	Psychotherapy
PERSD-S	Safety
PERSD-SM	Stress Management
PERSD-TLH	Tele-Health
PERSD-TX	Treatment

PDD PERVASIVE DEVELOPMENT DISORDER

PDD-BH	Behavioral and Emotional Health
PDD-C	Complications
PDD-CM	Case Management
PDD-CUL	Cultural/Spiritual Aspects of Health
PDD-DP	Disease Process
PDD-EX	Exercise
PDD-FU	Follow-up
PDD-HELP	Help Line
PDD-HPDP	Health Promotion, Disease Prevention
PDD-HY	Hygiene
PDD-IR	Information and Referral
PDD-L	Literature
PDD-LA	Lifestyle Adaptations
PDD-M	Medications
PDD-MNT	Medical Nutrition Therapy
PDD-N	Nutrition
PDD-S	Safety
PDD-SM	Stress Management
PDD-TLH	Tele-Health
PDD-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

PHOB PHOBIAS

PHOB-C	Complications
PHOB-CUL	Cultural/Spiritual Aspects of Health
PHOB-DP	Disease Process
PHOB-EX	Exercise
PHOB-FU	Follow-up
PHOB-HELP	Help Line
PHOB-IR	Information and Referral
PHOB-L	Literature
PHOB-M	Medications
PHOB-PSY	Psychotherapy
PHOB-SM	Stress Management
PHOB-TX	Treatment

PT PHYSICAL THERAPY

PT-AP	Anatomy and Physiology
PT-DP	Disease Process
PT-EQ	Equipment
PT-EX	Exercise
PT-FU	Follow-up
PT-GT	Gait Training
PT-I	Information
PT-L	Literature
PT-LA	Lifestyle Adaptations
PT-MNT	Medical Nutrition Therapy
PT-N	Nutrition
PT-TX	Treatment
PT-WC	Wound Care

PNM PNEUMONIA

PNM-AP	Anatomy and Physiology
PNM-C	Complications
PNM-CUL	Cultural/Spiritual Aspects of Health
PNM-DP	Disease Process
PNM-EQ	Equipment
PNM-EX	Exercise
PNM-FU	Follow-up
PNM-IS	Incentive Spirometry
PNM-L	Literature
PNM-LA	Lifestyle Adaptations
PNM-M	Medications
PNM-MNT	Medical Nutrition Therapy
PNM-N	Nutrition
PNM-P	Prevention
PNM-PM	Pain Management
PNM-SHS	Second-Hand/Third-Hand Smoke
PNM-TCB	Turn, Cough, Deep Breath
PNM-TE	Tests
PNM-TO	Tobacco
PNM-TX	Treatment

POI POISONING

POI-FU	Follow-up
POI-HELP	Help Line
POI-I	Information
POI-L	Literature
POI-P	Prevention
POI-TE	Tests
POI-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

PP	POSTPARTUM	PTSD	POSTTRAUMATIC STRESS DISORDER
PP-AP	Anatomy and Physiology	PTSD-C	Complications
PP-BH	Behavioral and Emotional Health	PTSD-CM	Case Management
PP-C	Complications	PTSD-CUL	Cultural/Spiritual Aspects of Health
PP-CUL	Cultural/Spiritual Aspects of Health	PTSD-DP	Disease Process
PP-EX	Exercise	PTSD-EX	Exercise
PP-FU	Follow-up	PTSD-FU	Follow-up
PP-HELP	Help Line	PTSD-HELP	Help Line
PP-INF	Infant Care	PTSD-L	Literature
PP-ISEC	Infant Security	PTSD-LA	Lifestyle Adaptations
PP-KE	Kegel Exercises	PTSD-M	Medications
PP-L	Literature	PTSD-P	Prevention
PP-LA	Lifestyle Adaptations	PTSD-PSY	Psychotherapy
PP-M	Medications	PTSD-SM	Stress Management
PP-MNT	Medical Nutrition Therapy	PTSD-TX	Treatment
PP-N	Nutrition		
PP-ORAL	Oral Health	PDM	PREDIABETES
PP-PPC	Pre-Conception Care	PDM-AP	Anatomy and Physiology
PP-PM	Pain Management	PDM-BH	Behavioral and Emotional Health
PP-WC	Wound Care	PDM-C	Complications
		PDM-CM	Case Management
PDEP	POSTPARTUM DEPRESSION	PDM-CUL	Cultural/Spiritual Aspects of Health
PDEP-C	Complications	PDM-DP	Disease Process
PDEP-CM	Case Management	PDM-EX	Exercise
PDEP-CUL	Cultural/Spiritual Aspects of Health	PDM-FU	Follow-up
PDEP-DP	Disease Process	PDM-HPDP	Health Promotion, Disease Prevention
PDEP-EX	Exercise	PDM-L	Literature
PDEP-FU	Follow-up	PDM-LA	Lifestyle Adaptations
PDEP-HPDP	Health Promotion, Disease Prevention	PDM-M	Medications
PDEP-IR	Information and Referral	PDM-MNT	Medical Nutrition Therapy
PDEP-L	Literature	PDM-N	Nutrition
PDEP-LA	Lifestyle Adaptations	PDM-P	Prevention
PDEP-M	Medications	PDM-PCC	Pre-Conception Care
PDEP-MNT	Medical Nutrition Therapy	PDM-SCR	Screening
PDEP-N	Nutrition	PDM-SM	Stress Management
PDEP-P	Prevention	PDM-TLH	Tele-Health
PDEP-PSY	Psychotherapy	PDM-TE	Tests
PDEP-S	Safety	PDM-TX	Treatment
PDEP-SM	Stress Management		
PDEP-TX	Treatment		

INDEX OF PATIENT EDUCATION PROTOCOLS

PN	PRENATAL	PU	PRESSURE ULCER
PN-1T	First Trimester (0 to 12 Weeks)	PU-AP	Anatomy and Physiology
PN-2T	Second Trimester (13-to 27 Weeks)	PU-C	Complications
PN-3T	Third Trimester (28 to 40 Weeks)	PU-CUL	Cultural/Spiritual Aspects of Health
PN-ADM	Admission to Hospital	PU-DP	Disease Process
PN-AOD	Alcohol and Other Drugs	PU-EQ	Equipment
PN-AP	Anatomy and Physiology	PU-FU	Follow-up
PN-BH	Behavioral and Emotional Health	PU-HM	Home Management
PN-C	Complications	PU-L	Literature
PN-CUL	Cultural/Spiritual Aspects of Health	PU-M	Medications
PN-DC	Dental Care	PU-MNT	Medical Nutrition Therapy
PN-DM	Pregnancy in Pre-Existing Diabetes	PU-N	Nutrition
PN-DV	Domestic Violence	PU-P	Prevention
PN-EX	Exercise	PU-PM	Pain Management
PN-FASD	Fetal Alcohol Spectrum Syndrome	PU-PRO	Procedures
PN-FU	Follow-up	PU-SCR	Screening
PN-GD	Growth and Development	PU-TE	Tests
PN-GDM	Gestational Diabetes	PU-TX	Treatment
PN-GENE	Genetic Testing	PU-WC	Wound Care
PN-HELP	Help Line	PSR	PSORIASIS
PN-HIV	Human Immunodeficiency Virus	PSR-AP	Anatomy and Physiology
PN-HTPN	Hypertension in Pregnancy	PSR-BH	Behavioral and Emotional Health
PN-IB	Insurance and Benefits	PSR-C	Complications
PN-L	Literature	PSR-DP	Disease Process
PN-LA	Lifestyle Adaptations	PSR-FU	Follow-up
PN-M	Medications	PSR-HELP	Help Line
PN-MNT	Medical Nutrition Therapy	PSR-L	Literature
PN-N	Nutrition	PSR-M	Medications
PN-PM	Pain Management	PSR-MNT	Medical Nutrition Therapy
PN-PTL	Pre-term Labor	PSR-N	Nutrition
PN-S	Safety	PSR-P	Prevention
PN-SHS	Second-Hand/Third-Hand Smoke	PSR-PRO	Procedures
PN-SM	Stress Management	PSR-SM	Stress Management
PN-SOC	Social Health	PSR-TX	Treatment
PN-STI	Sexually Transmitted Infections		
PN-TE	Tests		
PN-TO	Tobacco		
PN-VBAC	Vaginal Birth after Cesarean Section		

INDEX OF PATIENT EDUCATION PROTOCOLS

PSYD	PSYCHOTIC DISORDERS	PL	PULMONARY DISEASE
PYSD-C	Complications	PL-ADV	Advance Directive
PYSD-CM	Case Management	PL-AP	Anatomy and Physiology
PYSD-CUL	Cultural/Spiritual Aspects of Health	PL-BH	Behavioral and Emotional Health
PYSD-DP	Disease Process	PL-C	Complications
PYSD-EX	Exercise	PL-CM	Case Management
PYSD-FU	Follow-up	PL-CUL	Cultural/Spiritual Aspects of Health
PYSD-HPDP	Health Promotion, Disease Prevention	PL-DP	Disease Process
PYSD-HM	Home Management	PL-EQ	Equipment
PYSD-HY	Hygiene	PL-EX	Exercise
PYSD-IR	Information and Referral	PL-FU	Follow-up
PYSD-L	Literature	PL-HM	Home Management
PYSD-LA	Lifestyle Adaptations	PL-HY	Hygiene
PYSD-M	Medications	PL-IS	Incentive Spirometry
PYSD-MNT	Medical Nutrition Therapy	PL-L	Literature
PYSD-N	Nutrition	PL-LA	Lifestyle Adaptations
PYSD-PSY	Psychotherapy	PL-M	Medications
PYSD-S	Safety	PL-MDI	Metered-Dose Inhalers
PYSD-SM	Stress Management	PL-MNT	Medical Nutrition Therapy
PYSD-TLH	Tele-Health	PL-N	Nutrition
PYSD-TX	Treatment	PL-P	Prevention
		PL-PM	Pain Management
		PL-PRO	Procedures
		PL-SHS	Second-Hand/Third-Hand Smoke
		PL-TE	Tests
		PL-TO	Tobacco (Smoking)
		PL-TX	Treatment

INDEX OF PATIENT EDUCATION PROTOCOLS

PYELO PYELONEPHRITIS

PYELO-AP	Anatomy and Physiology
PYELO-C	Complications
PYELO-CM	Case Management
PYELO-CUL	Cultural/Spiritual Aspects of Health
PYELO-DP	Disease Process
PYELO-EQ	Equipment
PYELO-EX	Exercise
PYELO-FU	Follow-up
PYELO-HPDP	Health Promotion, Disease Prevention
PYELO-HM	Home Management
PYELO-HY	Hygiene
PYELO-L	Literature
PYELO-M	Medications
PYELO-N	Nutrition
PYELO-P	Prevention
PYELO-PRO	Procedure
PYELO-TE	Tests
PYELO-TX	Treatment

XRAY RADIOLOGY/NUCLEAR MEDICINE

XRAY-C	Complications
XRAY-EQ	Equipment
XRAY-FU	Follow-up
XRAY-L	Literature
XRAY-M	Medications
XRAY-PM	Pain Management
XRAY-PRO	Procedures
XRAY-S	Safety
XRAY-SCR	Screening
XRAY-TE	Tests

REACT REACTIVE ATTACHMENT DISORDER

REACT-C	Complications
REACT-CM	Case Management
REACT-CUL	Cultural/Spiritual Aspects of Health
REACT-DP	Disease Process
REACT-EX	Exercise
REACT-FU	Follow-up
REACT-HELP	Help Line
REACT-HPDP	Health Promotion, Disease Prevention
REACT-HY	Hygiene
REACT-L	Literature
REACT-LA	Lifestyle Adaptations
REACT-M	Medications
REACT-MNT	Medical Nutrition Therapy
REACT-N	Nutrition
REACT-P	Prevention
REACT-PA	Parenting
REACT-PSY	Psychotherapy
REACT-S	Safety
REACT-SM	Stress Management
REACT-TLH	Tele-Health
REACT-TX	Treatment

RH REACTIVE HYPOGLYCMIA

RH-C	Complications
RH-CM	Case Management
RH-CUL	Cultural/Spiritual Aspects of Health
RH-DP	Disease Process
RH-EX	Exercise
RH-FU	Follow-up
RH-HELP	Help Line
RH-HM	Home Management
RH-L	Literature
RH-LA	Lifestyle Adaptations
RH-M	Medications
RH-MNT	Medical Nutrition Therapy
RH-N	Nutrition
RH-P	Prevention
RH-S	Safety
RH-TE	Tests
RH-TX	Treatment

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RSV	RESPIRATORY SYNCYTIAL VIRUS	RA	RHEUMATOID ARTHRITIS
RSV-AP	Anatomy and Physiology	RA-AP	Anatomy and Physiology
RSV-C	Complications	RA-BH	Behavioral and Emotional Health
RSV-DP	Disease Process	RA-C	Complications
RSV-FU	Follow-up	RA-CM	Case Management
RSV-HM	Home Management	RA-CUL	Cultural/Spiritual Aspects of Health
RSV-L	Literature	RA-DP	Disease Process
RSV-M	Medications	RA-EQ	Equipment
RSV-MNT	Medical Nutrition Therapy	RA-EX	Exercise
RSV-N	Nutrition	RA-FU	Follow-up
RSV-NEB	Nebulizer	RA-HELP	Help Line
RSV-P	Prevention	RA-HM	Home Management
RSV-SHS	Second-Hand/Third-Hand Smoke	RA-HPDP	Health Promotion, Disease Prevention
RSV-TE	Tests	RA-HY	Hygiene
RSV-TO	Tobacco (Smoking)	RA-L	Literature
RSV-TX	Treatment	RA-LA	Lifestyle Adaptations
RST	RESTRAINTS	RA-M	Medications
RST-BH	Behavioral and Emotional Health	RA-MNT	Medical Nutrition Therapy
RST-EQ	Equipment	RA-N	Nutrition
RST-IR	Information and Referral	RA-PM	Pain Management
RST-L	Literature	RA-PRO	Procedures
RST-M	Medications	RA-PT	Physical Therapy
RST-MNT	Medical Nutrition Therapy	RA-S	Safety
RST-P	Prevention	RA-SM	Stress Management
RST-PM	Pain Management	RA-TE	Tests
RST-PRO	Procedures	RA-TLH	Tele-Health
RST-S	Safety	RA-TX	Treatment
RST-SM	Stress Management	RMSF	ROCKY MOUNTAIN SPOTTED FEVER
		RMSF-C	Complications
		RMSF-DP	Disease Process
		RMSF-FU	Follow-up
		RMSF-HELP	Help Line
		RMSF-L	Literature
		RMSF-M	Medications
		RMSF-MNT	Medical Nutrition Therapy
		RMSF-P	Prevention
		RMSF-TE	Tests
		RMSF-TX	Treatment

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SARC	SARCOIDOSIS	SZ	SEIZURE DISORDER
SARC-AP	Anatomy and Physiology	SZ-AP	Anatomy and Physiology
SARC-BH	Behavioral and Emotional Health	SZ-BH	Behavioral and Emotional Health
SARC-C	Complications	SZ-C	Complications
SARC-CM	Case Management	SZ-CUL	Cultural/Spiritual Aspects of Health
SARC-CUL	Cultural/Spiritual Aspects of Health	SZ-DP	Disease Process
SARC-DP	Disease Process	SZ-FU	Follow-up
SARC-EQ	Equipment	SZ-HELP	Help Line
SARC-EX	Exercise	SZ-L	Literature
SARC-FU	Follow-up	SZ-LA	Lifestyle Adaptations
SARC-HELP	Help Line	SZ-M	Medications
SARC-HM	Home Management	SZ-MNT	Medical Nutrition Therapy
SARC-HPDP	Health Promotion, Disease Prevention	SZ-PCC	Pre-Conception Care
SARC-HY	Hygiene	SZ-S	Safety
SARC-L	Literature	SZ-SM	Stress Management
SARC-LA	Lifestyle Adaptations	SZ-TE	Tests
SARC-M	Medications	SZ-TX	Treatment
SARC-MNT	Medical Nutrition Therapy	SEP	SEPARATION ANXIETY DISORDER
SARC-N	Nutrition	SEP-C	Complications
SARC-PCC	Pre-Conception Care	SEP-CM	Case Management
SARC-PM	Pain Management	SEP-CUL	Cultural/Spiritual Aspects of Health
SARC-PRO	Procedure	SEP-DP	Disease Process
SARC-SHS	Second-Hand/Third-Hand Smoke	SEP-EX	Exercise
SARC-SM	Stress Management	SEP-FU	Follow-up
SARC-TE	Tests	SEP-HELP	Help Line
SARC-TLH	Tele-Health	SEP-HPDP	Health Promotion, Disease Prevention
SARC-TX	Treatment	SEP-L	Literature
SARC-WC	Wound Care	SEP-M	Medications
SCBE	SCABIES	SEP-MNT	Medical Nutrition Therapy
SCBE-C	Complications	SEP-N	Nutrition
SCBE-DP	Disease Process	SEP-PA	Parenting
SCBE-FU	Follow-up	SEP-PSY	Psychotherapy
SCBE-HM	Home Management	SEP-SM	Stress Management
SCBE-HY	Hygiene	SEP-TLH	Tele-Health
SCBE-L	Literature	SEP-TX	Treatment
SCBE-M	Medications		
SCBE-P	Prevention		
SCBE-TX	Treatment		

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SARS	SEVERE ACUTE RESPIRATORY SYNDROME	STI	SEXUALLY TRANSMITTED INFECTIONS
SARS-AP	Anatomy and Physiology	STI-AP	Anatomy and Physiology
SARS-C	Complications	STI-BH	Behavioral and Emotional Health
SARS-DP	Disease Process	STI-C	Complications
SARS-FU	Follow-up	STI-CUL	Cultural/Spiritual Aspects of Health
SARS-HY	Hygiene	STI-DP	Disease Process
SARS-L	Literature	STI-FU	Follow-up
SARS-LA	Lifestyle Adaptations	STI-HELP	Help Line
SARS-M	Medications	STI-HPDP	Health Promotion, Disease Prevention
SARS-MNT	Medical Nutrition Therapy	STI-L	Literature
SARS-N	Nutrition	STI-M	Medications
SARS-P	Prevention	STI-P	Prevention
SARS-PRO	Procedures	STI-PCC	Pre-Conception Care
SARS-TE	Tests	STI-SM	Stress Management
SARS-TX	Treatment	STI-TE	Tests
		STI-TX	Treatment
SEX	SEXUAL DISORDERS	SHI	SHINGLES
SEX-AP	Anatomy and Physiology	SHI-AP	Anatomy and Physiology
SEX-BH	Behavioral and Emotional Health	SHI-BH	Behavioral and Emotional Health
SEX-C	Complications	SHI-C	Complications
SEX-CM	Case Management	SHI-DP	Disease Process
SEX-CUL	Cultural/Spiritual Aspects of Health	SHI-EX	Exercise
SEX-DP	Disease Process	SHI-FU	Follow-up
SEX-EX	Exercise	SHI-HELP	Help Line
SEX-FU	Follow-up	SHI-HPDP	Health Promotion, Disease Prevention
SEX-HPDP	Health Promotion, Disease Prevention	SHI-L	Literature
SEX-IR	Information and Referral	SHI-M	Medications
SEX-L	Literature	SHI-MNT	Medical Nutrition Therapy
SEX-LA	Lifestyle Adaptations	SHI-N	Nutrition
SEX-M	Medications	SHI-P	Prevention
SEX-PM	Pain Management	SHI-PM	Pain Management
SEX-PSY	Psychotherapy	SHI-SM	Stress Management
SEX-S	Safety	SHI-TE	Tests
SEX-SM	Stress Management	SHI-TX	Treatment
SEX-TX	Treatment		

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SINUS SINUSITIS

SINUS-AP	Anatomy and Physiology
SINUS-C	Complications
SINUS-CUL	Cultural/Spiritual Aspects of Health
SINUS-DP	Disease Process
SINUS-FU	Follow-up
SINUS-HELP	Help Line
SINUS-HM	Home Management
SINUS-L	Literature
SINUS-M	Medications
SINUS-P	Prevention
SINUS-PRO	Procedures
SINUS-TE	Tests
SINUS-TX	Treatment

SWI SKIN AND WOUND INFECTIONS

SWI-AP	Anatomy and Physiology
SWI-C	Complications
SWI-CUL	Cultural/Spiritual Aspects of Health
SWI-DP	Disease Process
SWI-EQ	Equipment
SWI-EX	Exercise
SWI-FU	Follow-up
SWI-HM	Home Management
SWI-HPDP	Health Promotion, Disease Prevention
SWI-HY	Hygiene
SWI-ISO	Isolation
SWI-L	Literature
SWI-M	Medications
SWI-MNT	Medical Nutrition Therapy
SWI-N	Nutrition
SWI-P	Prevention
SWI-PM	Pain Management
SWI-PRO	Procedure
SWI-TE	Tests
SWI-TX	Treatment
SWI-WC	Wound Care

SLEEP SLEEP DISORDERS

SLEEP-BH	Behavioral and Emotional Health
SLEEP-C	Complications
SLEEP-CM	Case Management
SLEEP-CUL	Cultural/Spiritual Aspects of Health
SLEEP-DP	Disease Process
SLEEP-EX	Exercise
SLEEP-FU	Follow-up
SLEEP-HPDP	Health Promotion, Disease Prevention
SLEEP-IR	Information and Referral
SLEEP-L	Literature
SLEEP-LA	Lifestyle Adaptations
SLEEP-M	Medications
SLEEP-N	Nutrition
SLEEP-PSY	Psychotherapy
SLEEP-S	Safety
SLEEP-SM	Stress Management
SLEEP-TE	Tests
SLEEP-TLH	Tele-Health
SLEEP-TX	Treatment

SNAKE SNAKE BITE

SNAKE-AP	Anatomy and Physiology
SNAKE-C	Complications
SNAKE-CUL	Cultural/Spiritual Aspects of Health
SNAKE-DP	Disease Process
SNAKE-EQ	Equipment
SNAKE-FU	Follow-up
SNAKE-HPDP	Health Promotion, Disease Prevention
SNAKE-HM	Home Management
SNAKE-L	Literature
SNAKE-M	Medications
SNAKE-P	Prevention
SNAKE-PM	Pain Management
SNAKE-PRO	Procedure
SNAKE-S	Safety
SNAKE-TE	Tests
SNAKE-TX	Treatment

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SOMA SOMATOFORM DISORDERS

SOMA-C	Complications
SOMA-CM	Case Management
SOMA-CUL	Cultural/Spiritual Aspects of Health
SOMA-DP	Disease Process
SOMA-EX	Exercise
SOMA-FU	Follow-up
SOMA-HPDP	Health Promotion, Disease Prevention
SOMA-L	Literature
SOMA-LA	Lifestyle Adaptations
SOMA-M	Medications
SOMA-MNT	Medical Nutrition Therapy
SOMA-N	Nutrition
SOMA-PM	Pain Management
SOMA-PSY	Psychotherapy
SOMA-S	Safety
SOMA-SM	Stress Management
SOMA-TE	Tests
SOMA-TLH	Tele-Health
SOMA-TX	Treatment

ST SORE THROAT (PHARYNGITIS/STREP THROAT)

ST-AP	Anatomy and Physiology
ST-C	Complications
ST-CUL	Cultural/Spiritual Aspects of Health
ST-DP	Disease Process
ST-FU	Follow-up
ST-HM	Home Management
ST-HY	Hygiene
ST-L	Literature
ST-M	Medications
ST-P	Prevention
ST-PM	Pain Management
ST-TE	Tests
ST-TX	Treatment

SPIDER SPIDER BITE

SPIDER-C	Complications
SPIDER-DP	Disease Process
SPIDER-FU	Follow-up
SPIDER-HM	Home Management
SPIDER-HY	Hygiene
SPIDER-L	Literature
SPIDER-M	Medications
SPIDER-P	Prevention
SPIDER-PM	Pain Management
SPIDER-TE	Tests
SPIDER-TX	Treatment
SPIDER-WC	Wound Care

STING STING, INSECT

STING-C	Complications
STING-DP	Disease Process
STING FU	Follow-up
STING-HM	Home Management
STING-L	Literature
STING-LA	Lifestyle Adaptations
STING-M	Medications
STING-P	Prevention
STING-PM	Pain Management
STING-TE	Tests
STING-TX	Treatment
STING-WC	Wound Care

SIDS SUDDEN INFANT DEATH SYNDROME

SIDS-BH	Behavioral and Emotional Health
SIDS-CUL	Cultural/Spiritual Aspects of Health
SIDS-HELP	Help Line
SIDS-HPDP	Health Promotion, Disease Prevention
SIDS-I	Information
SIDS-L	Literature
SIDS-P	Prevention
SIDS-S	Safety
SIDS-SHS	Second-Hand/Third-Hand Smoke
SIDS-SM	Stress Management

INDEX OF PATIENT EDUCATION PROTOCOLS

SB	SUICIDAL BEHAVIOR (SEE SI-SUICIDAL IDEATION AND GESTURES)	SPE	SURGICAL PROCEDURES AND ENDOSCOPY
		SPE-ADV	Advance Directive
		SPE-C	Complications
SI	SUICIDAL IDEATION AND GESTURES	SPE-CUL	Cultural/Spiritual Aspects of Health
SI-C	Complications	SPE-EQ	Equipment
SI-CM	Case Management	SPE-FU	Follow-up
SI-CUL	Cultural/Spiritual Aspects of Health	SPE-IS	Incentive Spirometry
SI-DP	Disease Process	SPE-L	Literature
SI-FU	Follow-up	SPE-M	Medications
SI-HELP	Help Line	SPE-PM	Pain Management
SI-HPDP	Health Promotion, Disease Prevention	SPE-PO	Postoperative
SI-IR	Information and Referral	SPE-PR	Preoperative
SI-L	Literature	SPE-PRO	Procedures
SI-M	Medications	SPE-TCB	Turn, Cough, Deep Breath
SI-PSY	Psychotherapy	SPE-TE	Tests
SI-S	Safety	SPE-WC	Wound Care
SI-SM	Stress Management	SYN	SYNCOPE
SI-TX	Treatment	SYN-AP	Anatomy and Physiology
SUN	SUN EXPOSURE	SYN-DP	Disease Process
SUN-C	Complications	SYN-EQ	Equipment
SUN-DP	Disease Process	SYN-EX	Exercise
SUN-L	Literature	SYN-FU	Follow-up
SUN-LA	Lifestyle Adaptations	SYN-L	Literature
SUN-P	Prevention	SYN-LA	Lifestyle Adaptations
SUN-TX	Treatment	SYN-M	Medications
SUP	SUPPLEMENTS, NUTRITIONAL/HERBAL	SYN-P	Prevention
SUP-C	Complications	SYN-PRO	Procedure
SUP-FU	Follow-up	SYN-S	Safety
SUP-HPDP	Health Promotion, Disease Prevention	SYN-SM	Stress Management
SUP-I	Supplement Information	SYN-TE	Tests
SUP-L	Literature	SYN-TX	Treatment
SUP-M	Medications		
SUP-MNT	Medical Nutrition Therapy		
SUP-N	Nutrition		
SUP-S	Safety		

INDEX OF PATIENT EDUCATION PROTOCOLS

TICD	TIC DISORDERS	TB	TUBERCULOSIS
TICD-C	Complications	TB-BH	Behavioral and Emotional Health
TICD-CM	Case Management	TB-C	Complications
TICD-CUL	Cultural/Spiritual Aspects of Health	TB-CM	Case Management
TICD-DP	Disease Process	TB-CUL	Cultural/Spiritual Aspects of Health
TICD-EX	Exercise	TB-DOT	Directly Observed Therapy
TICD-FU	Follow-up	TB-DP	Disease Process
TICD-HELP	Help Line	TB-FU	Follow-up
TICD-HPDP	Health Promotion, Disease Prevention	TB-HELP	Help Line
TICD-L	Literature	TB-L	Literature
TICD-LA	Lifestyle Adaptations	TB-M	Medications
TICD-M	Medications	TB-MNT	Medical Nutrition Therapy
TICD-PSY	Psychotherapy	TB-N	Nutrition
TICD-SM	Stress Management	TB-P	Prevention
TICD-TLH	Tele-Health	TB-SCR	Screening Skin Test
TICD-TX	Treatment	TB-TE	Tests
		TB-TX	Treatment
TO	TOBACCO USE	UC	ULCERATIVE COLITIS
TO-AP	Anatomy and Physiology	UC-AP	Anatomy and Physiology
TO-C	Complications	UC-BH	Behavioral and Emotional Health
TO-CUL	Cultural/Spiritual Aspects of Health	UC-C	Complications
TO-DP	Disease Process	UC-CM	Case Management
TO-EX	Exercise	UC-CUL	Cultural/Spiritual Aspects of Health
TO-FU	Follow-up	UC-DP	Disease Process
TO-HELP	Help Line	UC-FU	Follow-up
TO-HY	Hygiene	UC-HELP	Help Line
TO-IR	Information and Referral	UC-HPDP	Health Promotion, Disease Prevention
TO-L	Literature	UC-HY	Hygiene
TO-LA	Lifestyle Adaptations	UC-L	Literature
TO-M	Medications	UC-LA	Lifestyle Adaptations
TO-MNT	Medication Nutrition Therapy	UC-M	Medications
TO-N	Nutrition	UC-MNT	Medical Nutrition Therapy
TO-P	Prevention	UC-N	Nutrition
TO-PCC	Pre-Conception Care	UC-P	Prevention
TO-REL	Relapse Prevention	UC-PM	Pain Management
TO-QT	Quit	UC-PRO	Procedure
TO-S	Safety	UC-SM	Stress Management
TO-SHS	Second-Hand/Third-Hand Smoke	UC-TX	Treatment
TO-SM	Stress Management		

INDEX OF PATIENT EDUCATION PROTOCOLS

**URI UPPER RESPIRATORY
INFECTION**

URI-AP	Anatomy and Physiology
URI-C	Complications
URI-CUL	Cultural/Spiritual Aspects of Health
URI-DP	Disease Process
URI-FU	Follow-up
URI-HM	Home Management
URI-HY	Hygiene
URI-L	Literature
URI-M	Medications
URI-P	Prevention

**UTI URINARY TRACT
INFECTION**

UTI-AP	Anatomy and Physiology
UTI-C	Complications
UTI-CUL	Cultural/Spiritual Aspects of Health
UTI-DP	Disease Process
UTI-FU	Follow-up
UTI-HELP	Help Line
UTI-HM	Home Management
UTI-HPDP	Health Promotion, Disease Prevention
UTI-HY	Hygiene
UTI-L	Literature
UTI-M	Medications
UTI-MNT	Medical Nutrition Therapy
UTI-N	Nutrition
UTI-P	Prevention
UTI-PM	Pain Management
UTI-PRO	Procedure
UTI-TE	Tests
UTI-TX	Treatment

**UCATH URINARY CATHETER AND
ASSOCIATED INFECTION**

UCATH-AP	Anatomy and Physiology
UCATH-C	Complications
UCATH-DP	Disease Process
UCATH-EQ	Equipment
UCATH-FU	Follow-up
UCATH-HM	Home Management
UCATH-HY	Hygiene
UCATH-L	Literature
UCATH-LA	Lifestyle Adaptations
UCATH-M	Medications
UCATH-P	Prevention
UCATH-PM	Pain Management
UCATH-PRO	Procedure
UCATH-S	Safety
UCATH-TE	Tests
UCATH-TX	Treatment

**VENT VENTILATION
(MECHANICAL) AND
ASSOCIATED PNEUMONIA**

VENT-ADV	Advance Directive
VENT-AP	Anatomy and Physiology
VENT-C	Complications
VENT-DP	Disease Process
VENT-EQ	Equipment
VENT-EX	Exercise
VENT-HY	Hygiene
VENT-INT	Intubation
VENT-L	Literature
VENT-M	Medications
VENT-MNT	Medical Nutrition Therapy
VENT-N	Nutrition
VENT-P	Prevention
VENT-PM	Pain Management
VENT-PRO	Procedure
VENT-S	Safety
VENT-TE	Tests
VENT-TX	Treatment
VENT-VAP	Ventilator-Associated Pneumonia

INDEX OF PATIENT EDUCATION PROTOCOLS

WNV	WEST NILE VIRUS	WH	WOMEN'S HEALTH
WNV-C	Complications	WH-AP	Anatomy and Physiology
WNV-DP	Disease Process	WH-BE	Breast Exam
WNV-EQ	Equipment	WH-BH	Behavioral and Emotional Health
WNV-FU	Follow-up	WH-CRC	Colorectal Cancer Screening
WNV-HPDP	Health Promotion, Disease Prevention	WH-COLP	Colposcopy
WNV-L	Literature	WH-CRY	Cryotherapy
WNV-LA	Lifestyle Adaptations	WH-CUL	Cultural/Spiritual Aspects of Health
WNV-M	Medications	WH-EX	Exercise
WNV-MNT	Medication Nutrition Therapy	WH-FP	Family Planning
WNV-N	Nutrition	WH-FU	Follow-up
WNV-P	Prevention	WH-HELP	Help Line
WNV-PRO	Procedures	WH-HPDP	Health Promotion, Disease Prevention
WNV-TE	Tests	WH-HY	Hygiene
WNV-TX	Treatment	WH-IM	Immunizations
		WH-KE	Kegel Exercises
		WH-L	Literature
		WH-LP	LEEP
		WH-M	Medications
		WH-MAM	Mammogram
		WH-MNT	Medical Nutrition Therapy
		WH-MP	Menopause
		WH-MS	Menses
		WH-N	Nutrition
		WH-OS	Osteoporosis
		WH-PAP	Pap Smear / Pelvic Exam
		WH-PCC	Pre-Conception Care
		WH-PMS	Premenstrual Syndrome
		WH-PRO	Procedure
		WH-S	Safety
		WH-SM	Stress Management
		WH-STI	Sexually Transmitted Infections
		WH-SX	Sexuality
		WH-TE	Tests

INDEX OF PATIENT EDUCATION PROTOCOLS

YEAST YEAST INFECTION

YEAST-AP	Anatomy and Physiology
YEAST-C	Complications
YEAST-CM	Case Management
YEAST-CUL	Cultural/Spiritual Aspects of Health
YEAST-DP	Disease Process
YEAST-EX	Exercise
YEAST-FU	Follow-up
YEAST-HELP	Help Line
YEAST-HM	Home Management
YEAST-HPDP	Health Promotion, Disease Prevention
YEAST-HY	Hygiene
YEAST-L	Literature
YEAST-M	Medications
YEAST-N	Nutrition
YEAST-P	Prevention
YEAST-PM	Pain Management
YEAST-PRO	Procedure
YEAST-SM	Stress Management

YEAST-TE	Tests
YEAST-TX	Treatment
YEAST-WC	Wound Care

DIABETES CURRICULUM EDUCATION

DMC-ABC	Knowing Your Numbers	DMCN-EL	Exchange Lists
DMC-AC	Acute Complications	DMCN-FS	Food Shopping
DMC-BG	Behavioral Goals	DMCN-HC	Healthy Cooking
DMC-BGM	Home Blood Sugar Monitoring	DMCN-EA	Eating Away from Home
DMC-CC	Chronic Complications	DMCN-AL	Use of Alcohol
DMC-DP	Disease Process	DMCN-D	Evaluating Diets
DMC-EX	Exercise	DMCPG-DM	Pregnancy, Diabetes and You
DMC-FTC	Foot Care	DMCPG-N	Healthy Eating
DMC-M	Diabetes Medicine	DMCPG-EX	Moving to Stay Healthy
DMC-MSE	Mind, Spirit And Emotion	DMCPG-M	Medicines
DMC-N	Healthy Eating	DMCPG-BGM	Blood Sugar Monitoring
DMC-PPC	Pre-Pregnancy Counseling	DMCPG-S	Staying Healthy During Pregnancy
DMCN-FL	Introduction to Food Labels	DMCPG-PP	Staying Healthy After Delivery
DMCN-CC	Carbohydrate Counting		

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

INDEX OF PATIENT EDUCATION PROTOCOLS

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-DEMN	Dementia
BAR-DNRE	Does Not Read English
BAR-ESLA	Speaks English as a Second Language
BAR-FIMS	Fine Motor Skills Deficit
BAR-HEAR	Hard Of Hearing
BAR-INTN	Interpreter Needed
BAR-LOWLIT	Low Health Literacy
BAR-NONE	No Barriers
BAR-STRESS	Social/Emotional Stress
BAR-VALU	Values/Belief
BAR-VISI	Visually Impaired
LP-DOIT	Do
LP-GP	Group
LP-READ	Read
LP-MEDIA	Media
LP-TALK	Talk
RL-DSTR	Distraction
RL-EAGR	Eager
RL-INTX	Intoxication
RL-RCPT	Receptive
RL-PAIN	Pain
RL-SVIL	Severity of Illness
RL-UNRC	Unreceptive