GOAL:

1. To improve patient outcomes by educating patients and families to promote recovery, adjustment and healthy behavior, utilizing a multidisciplinary approach.

2. To provide guidelines for the use of the Patient/Family Education Record.

POLICY:

1. All patients, identified family members and/or significant others are provided with appropriate education and training pertinent to the diagnosis, problems or needs identified during initial and ongoing assessment.

2. Assessment of needs, readiness, and ability to learn will take into account the individual's literacy and educational level, age specific/developmental needs, cultural considerations, emotional barriers and motivators, physical or cognitive limitations, and the financial impact of care decisions.

3. The nurse and physician or designated staff are primary coordinators of patient/family education and have responsibility for ensuring the patient receives appropriate educational activities. Outpatient education will be rendered by competent staff as delegated by individual departments/programs.

4. The patient and family are provided specific knowledge and skills to cope with health care needs. These instructions include, but are not limited to:

    a. Expanding the patient's knowledge and understanding of their diagnosis and treatment needs.

    b. The safe and effective use of equipment ordered for their use.

    c. Dietary requirements and any potential interactions with medications.

    d. How and when to take medications in a safe and effective manner and (any specific precautions related to their needs.)

    e. Instruction in rehabilitation techniques to facilitate adaptation to and/or functional independence in the environment.

    f. Directions on who to contact and how to contact people (i.e. physicians, outside agencies, etc.) for further information regarding their care and treatment.

    g. How to access available community resources as needed.

    h. Providing an opportunity for the patient and/or family to ask questions that allow them to make informed decisions concerning their care and treatment.

    i. Clearly informing patients and families as to what their responsibilities are in the patient's care.

    j. Providing information about rehabilitation potential and resources.

    k. Promoting maximum achievable recovery and functioning.

5. The Patient/Family Education Committee will serve as one resource to review hospital wide policies relating to patient education, to coordinate patient/family education efforts interdepartmentally, and to plan continuous quality improvement - activities related to patient/family education.

6. Patient Education requires documentation in the patient's medical record. This will be done in the Patient/Family Education section of the chart on the Patient/Family Education Record by all disciplines involved in education.

7. To ensure hospital wide quality and consistency, any new or revised patient education documentation forms or checklists shall be approved by the Patient/Family Education Committee. (See procedure below)

PROCEDURE FOR USING "PATIENT/FAMILY EDUCATION RECORD":

1. The Patient/Family Education Record will be utilized for all in-patients.

2. The Patient/Family Education Record will be utilized for any short stay patients if more than one discipline is involved with the patient/family.

3. Part I includes an assessment of learning needs and readiness, and a reference of disciplines involved in patient education.

   a. Part I of the Patient/Family Education Record will be initiated on each patient on admission by the admitting nurse.

   b. Each discipline involved in patient/family education documents the date education initiated, and prints their name under section titled "Disciplines Involved in Patient Education".

4. Part II of the "Patient/Family Education Record" begins with a "Key" to abbreviations used in the record. Then Part II allows professionals to easily note which educational needs are addressed, to whom the education is provided, how it is provided, and the patient or family's response. There is also space for a brief summary of information taught.

   a. Each discipline involved in patient/family education documents a summary of education in Part II at least one time. This will allow all disciplines to communicate the status of each patient/family's education.

   b. Disciplines with previously approved teaching checklists or forms may continue to use them. These forms should be filed immediately behind the "Patient/Family Education Record" in the Patient/Family Education section of the chart.

   c. Disciplines accustomed to documenting education in their own sections of the chart may continue to do so, as long as they initialize their involvement in Part I, and briefly summarize teaching in Part II.