

Purpose

To define a systematic approach to patient and family education throughout the hospital.

Scope

The scope includes the entire Spring Grove Hospital patient and resident population, all clinical staff, and, as appropriate, those who will play a significant role in the patient's care in the community.

Policy Statement

It is the policy of Spring Grove Hospital Center to:

1. Educate the patient and/or, as appropriate, the patient's family and/or the individual significant other(s) centrally involved in the patient's life.
2. Improve patient health outcomes by promoting recovery, speedy return to function, promoting healthy behavior and to appropriately involve the patient in his or her care decisions.
3. Utilize the Patient/Family Education Record (SGPE-1) to document teaching and evaluation of such teaching.

Responsibility

The clinical disciplines and teams are responsible for identifying self-care knowledge deficits and learning needs of patients. This is a continuous process which begins on admission. Once a need or deficit is identified, the appropriate discipline will provide for the patient/family education or make a referral to an appropriate source.

Procedure

I. Assessment

- A. The treatment team and appropriate clinical discipline will evaluate the patient's learning needs, based on all available information.
- B. Based on the assessment, the educational instructions may include, but are not limited to such topics as:
 - Activities of Daily Living
 - Diet/Nutrition
 - Advance Medical Directives
 - HIV

- Medication (purpose, side effects, routine, food/drug interaction) to be given to patient upon LOA or Discharge
- Tuberculosis
- Safe & Effective Use of Medical Equipment
- Dental Self-Care
- Physical Therapy - Rehabilitation Techniques
- Knowledge of Condition (illness, testing & treatment)
- Community Resources (out-patient clinic, medical & community aftercare planning)
- Individual Treatment Plan
- Pain Management
- Conflict Resolution

C. The assessment should also include consideration of such variables as:

1. The educational level of the patient and family
2. Individual Learning Style
3. Type of discharge environment
4. Understanding of current health problem and reason for hospitalization
5. Psychosocial stressors and relationship to ability to learn
6. Individual cultural and religious practices.
7. Desire and motivation
8. Language barriers

Note: As appropriate and necessary, the learning abilities of a patient's family should be considered. Additionally, staff should ask the family if there are any special educational needs for which they require information.

II. Planning

- A. The treatment team will determine the extent to which the teaching should be incorporated into the treatment plan.
- B. A plan for patient and family teaching may include more than one discipline, depending on the problem. Other clinical disciplines

and resource personnel will plan individual teaching needs as determined by their assessment.

III. Implementation

- A. Teaching will use appropriate learning principles applicable to the variables previously described in Section I C.
- B. Implementation of patient and family education activities may consist of formal teaching plans or informal learning opportunities for individuals, families and/or groups. Staff will determine which educational formats are appropriate for specific learning needs.
 1. Appropriate hospital and community resources will be utilized. These may include printed materials, as well as auditory and visual formats.
 2. At the time of discharge the responsibilities of the patient and family for the continuation of care will be explained. Additional written instructions (aftercare plan, nursing discharge summary) will be provided to the patient.

IV. Documentation & Evaluation

After the Treatment Team and the appropriate clinical disciplines have evaluated the patient's learning needs, the form "Patient/Family Education Record," (SGPE-1), will be used to document in the patient record educational instructions given to patients/families/guardians. These instructions are determined by learning needs identified in the ITP or individual patient assessments done by the various clinical disciplines.

The form Patient/Family Education Records is to be filled out completely as follows:

- A. Fill in **Patient's Name** and **Unit**. Use addressograph in upper right hand corner.
- B. **SUBJECT** section - select appropriate topic, e.g., **MEDICATION** or fill in **SUBJECT** section as appropriate. At the bottom of **SUBJECT** section identify person to whom education is given at area marked **LEARNER**. See codes at bottom of page **LEARNER** code, e.g., **PT**=patient.
- C. **STAFF INITIALS** - Fill in initials of staff member giving instruction. Initials are to be

the same as used in the **SIGNATURE/INITIALS** section below.

- D. **DATE/TIME** - Write date and time instructions were given.
- E. **METHOD CODE** - Indicate method of instruction using codes for **METHOD CODES** on bottom of page. More than one code may be used.
- F. **CONTENT OF EDUCATION** - Briefly describe what was taught to the patient/family. (If insufficient space, use the progress notes to continue the documentation.)
- G. **RESPONSE CODE** - Use code from **RESPONSE CODE** section at bottom of page to describe the response of the patient/family to your teaching.
- H. **SIGNATURE/INITIALS** - All who use this form are to legibly place their signatures and initials in this section.

Additional pages of the form may be placed in the patient record as needed. These forms shall be filed in the Patient Education section of the patient record.

Reference

Form: Patient/Family Education Record SPPE-1.

Approved by


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 Andrea A. Braid, MHA, NHA, Chief Executive Officer

2/16/17
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