

SAMPLE: Health Education Protocol

Policy: Education helps patients gain knowledge and skills in order to meet ongoing health care needs. The patient will receive education and training specific to the patient's needs and as appropriate to the care, treatment and services provided.

Patients must be given sufficient information to make decisions and to take responsibility for self-management activities related to their needs. Patient and, as appropriate, their families are educated to improve individual outcomes by promoting healthy behavior and appropriately involving patient in their care, treatment, and service decisions.

Learning styles vary, and the ability to learn can be affected by many factors including individual learning preferences and readiness to learn. Educational activities must be tailored to meet the patient's needs and abilities.

1. Education provided is appropriate to the patient's needs.
2. The assessment of learning needs addresses cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication as appropriate.
3. As appropriate to the patient's condition and assessed needs, the patient is educated about the following:
 - a. The plan for care, treatment and services
 - b. Basic health practices and safety
 - c. The safe and effective use of medications
 - d. Nutrition interventions, modified diets, or oral health
 - e. Safe and effective use of medical equipment or supplies when provided
 - f. Understanding pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management.
 - g. Habilitation or rehabilitation techniques to help the patient reach maximum independence.
4. Education provided is appropriate to the patient's abilities.
5. Education is coordinated among the disciplines providing care, treatment, and services.
6. The content is presented in an understandable manner.
7. Teaching methods accommodate various learning styles.
8. Comprehension is evaluated.

Procedure:

1. The assessment of preferred language, preferred teaching method and educational level is completed on the registration form located in the front of the chart. The provider, clinical staff or health educator should refer to this information when conducting his/her learning assessment.
2. The provider will use the Ask – Tell – Ask method as the patient teaching process.
 - Ask – What does the patient need to know?
 - What does the patient want to know?
 - Tell - Tell the patient using plain language.
 - Ask - Ask the patient to repeat back
 - Ask the patient to show you.
3. The provider will assess for learning barriers and using the codes, document any barriers to learning, including “N” if there are no barriers. The provider will document approaches to reducing barriers (ie. rescheduling education session, translation services, follow-up clinical visit, or low health literacy education materials).
 - N-None
 - P-Pain/Discomfort
 - A-Anxiety/Fear
 - D-Denial/Lack of Motivation
 - B-Basic Needs Concerns
 - C-Cultural/Religious
 - P-Physical Limitations
 - T-Time Constraint
 - LL-Low Health Literacy
 - L-Language
4. The provider will assess patient’s understanding of health education by asking the patient to repeat back, asking questions, and by observing a return demonstration of skills. The provider will document patient’s understanding of health education in the progress notes.

Multidisciplinary Patient/Teaching Record:

1. The Multidisciplinary Patient/Teaching Record is used in the Family Medicine Department to document the teaching process.
2. The form should be completed on each patient (and/or family member) when education is provided by clinical support staff, i.e., licensed nurse, case managers, trained medical assistants and/or health education staff.

3. This teaching record provides an opportunity for the “Health Care Team” to document patient education on an on-going basis. The tool utilizes a series of codes to document the following information:
 - a. Diagnosis (es): Write in appropriate diagnosis (es) for today’s patient teaching session.
 - b. Date of instruction: Write the date of instruction
 - c. Assessment of Barriers: Using the codes, document any barriers to learning. Document “N” if there are no barriers. Comment on other side approaches to reducing barriers or reschedule education session for another time.
 - d. Identification of the Learner: Using the codes, document the learner(s).
 - e. The learners and or families readiness to learn: Using the codes, document the patient’s readiness to learn.
 - f. Methods of instruction utilized: Using the codes, document the method utilized for teaching.
 - g. Topics Presented: Document topics covered in learning session. The names of standardized curriculum can be used such as “Fever is Your Friend”.
 - h. Teaching Resources/Handouts: Document any handouts or materials utilized in the teaching session.
 - i. Response to Teaching: Using the codes, document the patient’s response to the teaching.
 - j. The educator should initial the teaching session.
4. Document your name, signature and discipline in the lower left corner.
5. The patient’s label should be placed in the lower right corner.
6. The other side of the form can be utilized for additional notes or follow-up if needed.
7. The form can be used for subsequent patient education on the same subject, different subjects and by different members of the “Health Care Team”.
8. The form is filed as the first page under “Patient Education” section of the medical record.

Family Planning Health Education Form: The Family Planning Health Education Form will be used in Women’s Health and HIV.

1. This form should be completed on each patient and/or family member by clinical support staff, i.e., licensed nurse, case managers, trained medical assistants and/or health education staff.
2. The following information will be documented on the “Family Planning Health Education” Form (see attached):
 - a. assessment of learning readiness/barriers to learning;
 - b. key teaching method(s);
 - c. knowledge or skill ability;
 - d. learning session content;
 - e. who received the education;
 - f. signature of the clinical support staff performing the education. In addition, the

patient/parent/guardian/ caretaker or family member will acknowledge receipt and understanding of the education provided by signing next to the date the education was given.

3. Refer to the California Family Health Council (CFHC) Health Worker Manual for content outlines.
4. The forms are filed under the “Patient Education” section of the patient medical record.
5. A reassessment of patient learning needs/barriers to learning should be conducted as needed and is determined by the clinical support staff providing the education. If patient’s conditions, problems or living situations change, reassessment of the learning needs and barriers to learning is recommended to determine whether these changes can/will impact the patient’s ability to make behavioral changes.
6. Instructions for using the Family Planning Health Education Form

A. Top Section: Assessment of Learning Readiness/Barriers to Learning

Complete this section the first time the patient receives education.

- 1) Check preferred language.
- 2) Check appropriate barriers to learning, e.g., patient only speaks Spanish, “check “Language” box. If there are no barriers, check “None” box.
- 3) Write intervention(s) to address the barrier(s). *Be brief.*
- 4) Ask the patient/learner how they prefer to learn. If they have no preference, check the “no preference” box.

B. Bottom Section: Patient Education/ Instructions:

Complete this section the first time the patient/learner receives education/ instruction (will usually be completed on the same day as the Assessment/ Reassessment of Learning Readiness/Barriers to Learning.

- 1) Write in appropriate diagnosis(s) for today’s patient teaching session.
- 2) Check if learner is ready to learn.
 - a. If no, e.g., patient has just been diagnosed with diabetes and is too upset to learn, check “No” box and comment. Make a new education appt., sign form and have patient sign form.
 - b. If yes, check “Yes” Box and continue with form.
- 3) Check the education provided. (Headings and topics under each heading are listed alphabetically.
- 4) Comments: Use to write *short* notes *if needed* (i.e., name of pamphlet, f/u needed). Write referral(s) if applicable.
- 5) Check or write in appropriate language in “Instructed In” box.
- 6) Check who received the education
- 7) Check the teaching method(s) used.
- 8) Circle the knowledge level of the patient after instruction.
- 9) Circle skill level of patient (if appropriate).
 - a. If knowledge and/or skill level are the same for all topics, circle appropriate knowledge level and/or skill level in boxes.

- b. If knowledge and/or skills levels are different for each topic, write the appropriate knowledge and/or skill symbols (e.g., K1, K2, K3, S1, S2, S3) to the left of each topic taught, or
 - c. **Circle** the symbol(s) that applies to the majority of topics and **write** to the left of each topic the appropriate symbol for a different level of knowledge.
- 10) Sign form and write your title.
 - 11) Have patient, a family member, caretaker sign form acknowledging that they understood information provided.
 - 12) File tools in the “Health Education” section of the medical record.

C. Reassessments

- 1) If patient’s conditions, problems or living situations change, reassessment of the learning needs and barriers to learning is recommended to determine whether these changes can/will impact the patient’s ability to make behavioral changes. The clinical support staff providing the education makes this determination.
- 2) Complete entire form, sign, ensure that patient/care taker signs, and place under “Health Education” section of chart on top of other Patient and Family Educational Record Forms.

External Citation: <http://www.healthed.org/Training/fphw.htm>

Codes/Regulations/Accreditation Standards: Title X Program Guidelines, Section 7.1 page 13