I. PURPOSE

To define the policy, procedure and responsibility of the Patient Education Program at SUNY Downstate Medical Center University Hospital of Brooklyn and its satellite centers as it relates to the planning, coordination, management, and quality of patient/family education.

II. DEFINITION

Patient / family education is an individualized, systematic, structured process to assess and impart knowledge. Additionally, it is to develop skills in order to effect changes in behavior\(^1\). The goal is to increase comprehension and participation in the self-management of health care needs. The patient/family/significant is integral with the development of an individualized plan of care and directed goals to meet outcomes.

III. POLICY

Patient/family education is an interdisciplinary and collaborative process designed to meet the educational needs of the individual patient/family throughout the continuum of care. All patients and their families are provided with appropriate education and training pertinent to their diagnosis, prevention, and health maintenance identified during initial and ongoing assessments. Educational materials may be provided to patients as a reinforcement or resource for teaching and should be provided in their primary language or with the assistance of a qualified interpreter whenever possible.
The interdisciplinary health care team is responsible for the following:

- Assesses patient and family needs for information, understanding and/or skills inclusive of special communication needs, interpreters (language, deaf-talk).
- Identifies, plans, and coordinates the patient/family teaching interventions necessary to meet ongoing healthcare educational needs.
- Initiates interventions designed to address specific learning needs.
- Evaluates the learners response and documenting/communicating the outcomes and needs for follow-up teaching.

IV. RESPONSIBILITIES


Coordination of patient/family educational support and resources in the hospital shall be the responsibility of the Patient Education Department in collaboration with other services / department (e.g. in developing teaching tools, guidelines, protocols, educational handouts and materials for specific patient population as needed).

V. PROCEDURES / GUIDELINES

A. Assessment / Re-assessment of Patient / Family Learning Needs

The physician, the nurse and other health care team members as appropriate, assess the patient/family learning needs during the pre-admission, admission, hospital stay, discharge phases of hospitalization and ambulatory care / follow-up visits as needed.

Assessment/ re-assessment data are documented in the Education Log on the Electronic Medical Record. (See P&P “Assessment of Patients” # ASSESS-01).

The patient and family educational process shall include assessment and individualized plan of care to include patients/families learning needs, activities, preferences, and readiness to learn. Considerations shall be given to:

- Cultural and religious practices
- Emotional barriers
- Physical and cognitive limitations
- Barriers to Communication (i.e. Language, unable to speak)
- Health literacy
- Desire and motivation to learn
- Financial implication of care choices
- Length of stay
B. Patient / Family Education Planning

The physicians, nurses, the patient / family and other health care team members as appropriate, develop the patient/ family educational plan which is integrated in the overall plan of care. This plan serves as the blueprint for the patient and family education activities used by the interdisciplinary health care team members. The patient/ family education process shall include as appropriate to assess the needs of the patient:

a. The plan for care, treatment and services.
b. Basic health practices and safety including oral health.
c. Safe and effective use of medications.
d. Nutrition interventions and modified diets.
e. Safe and effective use of medical equipment or supplies when provided by the hospital.
f. Importance of understanding effective pain management, assessment process, risk, and methods prescribed to achieve optimal comfort measures.
g. Habilitation or rehabilitation techniques to help patients reach maximum independence possible.
h. Smoking cessation interventions/support.
i. Immunization information.
j. HIV testing options
k. Advanced Directives
l. Access and use of community resources.
m. Continuity of academic education to hospitalized children (see P&P “Academic Education to Children and Youth” # PFED-2).
n. When and how to obtain further treatment if needed.
o. Regarding the patient’s ongoing health care needs.
p. Maintenance of good personal health practices, including oral hygiene.
q. Fall reduction strategies
r. The hospital provides the patient and/or family education on how to communicate concerns about patient safety issues that occur before, during, and after care is received (Family Alert Response System)
s. Evaluate patient satisfaction with health information provided.

C. Implementation of Patient/Family Education Plan

The written educational plan is implemented by the appropriate interdisciplinary health care team members using a variety of teaching/ learning methods that foster understanding of the material. The content is presented in an understandable manner (e.g. language, sign language for the hearing impaired/deaf, interpreter). The educational plan will be reviewed every shift and updated as needed. The teaching methods may include:

- Verbal instructions
- Written health education programs / health literature that has been approved and distributed by the Patient Education Department
- On-line educational resources on the Electronic Medical Record will be given to patients/families/significant other
- Approved computerized patient education medication handouts that must be given to patients with every new medications.
• Closed Circuit T.V. (CCTV) programs/ audiovisual
• Group teaching classes
• Demonstration/return demonstration
• Community resources and referrals to programs that can meet special needs

D. Discharge Planning

• Discharge folder to be given at the time of admission or shortly after being admitted to the unit.
• Discharge planning is initiated on initial assessment and is ongoing
• Discharge instructions are given to the patient and / or family or caregiver in a manner that they can understand.
• The patient and family are educated on how to obtain continuing care, treatment and services to meet his/her identified needs.

E. Evaluation of Outcomes

• The patient’s and family’s understanding of learning needs are continually evaluated by members of the health care team.
• Evaluate learning objectives via return demonstration and / or verbal discussion / follow-up care².
• When behavioral objectives are not met, revision of the educational plan with alternate educational strategies are utilized and re-evaluated by members of the health care team.

F. Documentation of Patient/ Family Education

Patient / Family Education is documented in the Education Log on the Electronic Medical Record.

G. Review and Approval of Patient Education Materials

The content of the patient education materials are periodically submitted to experts for review and revision. The experts may include physicians, nurses, therapists, pharmacists, dietitians, social workers, and other healthcare professionals with expertise in the content area. It is then submitted to the Patient Education Department. Patient and Family Education Committee may convene as needed for review, additional revisions, and approval. This process shall include:

• Evaluation of material for demonstrated need
• Visual effectiveness
• Potential duplication or replacement of existing patient education materials
• Format
• Graphics
• Cost
• Length
• Readability
• Grade reading level (4th grade)

VI. ATTACHMENTS:
None

VII. REFERENCES:


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<td>Yes</td>
<td>Maria Yomtov, MSN, RN, Director of Nursing, Patient Education Dept.</td>
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