

Effective Documentation of Patient and Family Education

Overview:

The diagnosis of “knowledge deficit” must be included by the nurse on every patient’s Common Patient Problem Intervention Outcome sheet on admission and specify the area of the deficit (i.e. knowledge deficit r/t po anticoagulation use). A plan of care that is reflective of the unique and individualized education needs of the patient and family is developed to address the deficit and documented on the Common Patient Problem Intervention Outcome sheet. Health profession staff will document patient education using department appropriate format that may include the written progress note or designated clinical form. When teaching occurs, the progress note must capture the educational intervention(s) and the patient’s/family’s response to the intervention. Documentation should include four components: assessment, action, evaluation, and follow up:

- Assessment describes what the patient already knows about his or her disease or hospitalization and so identifies the information or concepts to teach.
- Action is the interactive teaching component. After teaching patient education or techniques, have the patient, family member or friend, verbalize or show back what they learned.
- Evaluation describes how the patient reacted to the information taught. Was the patient or their family member or friend able to verbalize or demonstrate understanding of the concept?
- The follow up should include any additional teaching and reinforcement that needs to take place. It provides guidance for the next clinician to know where to begin patient education.

Examples of Progress Note Documentation:

1. Knowledge Deficit r/t new insulin dependent diabetes diagnosis:

Pt. given education on diabetes management through out the day; in the morning he stated his only experience with diabetes was that “both my parents had problems with their sugars when they were older”. At breakfast, pt. was taught to check his blood sugar and inject himself with insulin. Using verbal coaching, he demonstrated appropriate technique when checking his blood sugar and providing subcutaneous insulin in his abdomen. At lunch, the patient checked his blood sugar on his new home glucometer with verbal coaching from the RN. While filling out the dinner and breakfast menus, this RN engaged the patient in discussion of meals choices. The menus list carbohydrate content and the pt. verbalized some understanding that higher numbers of carbohydrates indicate more sugar. The patient’s sister, whom he lives with, visited in the late afternoon. Pt. and his sister practiced selecting the appropriate amount of insulin on the sliding scale and then drawing up the insulin from the vial. Each person was able to correctly draw up the appropriate amount of insulin with verbal cues. Both the patient and his sister were able to demonstrate proper technique on their own of injecting insulin at supper time. Continue to use show back until patient can independently demonstrate insulin injection and blood sugar checks.

2. Knowledge Deficit r/t catheterization:

Prior to the going to the catheterization lab, the pt’s wife verbalized concern that her husband will “have an accident on the table if they use the groin site”. This RN provided the pt. and his wife with coping support prior to the procedure and then verbal education about possible catheterization sites. After, they watched the education video on coronary angiography and angioplasty on the MGH Patient Education Channel. Both the patient and his wife stated possible entry sites back to the RN and expressed less anxiety about the procedure.