The patient's and family's understanding of learning needs shall be continually evaluated by members of the health care team. Evaluating learning objectives can be done via return demonstration and/or verbal discussion/follow-up care. 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

PFE.7 All patient education activities are documented in the patient's medical record.

PFE.7.1 The educational needs assessment and planning is documented in the patient's medical record.

PFE.7.2 The patient's response to education is documented in the patient's medical record.

Standard Intent:

When teaching takes place, all instructions should be documented as soon as they are given include who the learner was - the patient and/or a family member, the needs assessment, the educational plan, and the patient response. The documentation should be evident in the patient's medical record with clear identification of the staff member/s involved in the education process.

Patient & Family Education and Rights Standard Intents