AMERICAN HEALTH CONSULTANTS®

ED NURSING™

Vol. 3, No. 12

Inside

■ **Do you know what you need to document for restraint?** Use this checklist to comply 151

■ **Update on the Joint Commission and HCFA:** Find out how their standards for restraint differ 152

■ **Controversy:** Are you following HCFA's 'one-hour' rule? 153

■ **Medical/surgical vs. behavioral health standards:** You might be using the wrong standards for restraint 153

■ **Key points of new standards** — Staff need to be trained to reduce restraint use 154

■ **Educational materials for patients:** How to tell if yours are effective 154

■ **Patient reading levels:** A 90-second test for patients. 157

■ **Journal Reviews**. 158

■ **Tip of the month:** Speed care of patients on backboards. 159

■ **Inserted in this issue:** Mosby's Patient Teaching Guides for injury prevention for older adults, fractures, abdominal pain, domestic violence, grief, congestive heart failure, and ED discharge instructions; Rapid Estimate of Adult Literacy in Medicine test

October 2000

Warning! Surveyors won't hold back in evaluating new restraint standards

Restraint, seclusion is No. 1 cause of Type 1s, 'margin for error is slim'

Are you often too busy to make an effort to contact family members of patients in restraints? Do you document the need for restraint by describing the patient's diagnosis? Is chronic short staffing ever a factor in the decision to place a patient in restraint?

If the answer to any of these questions is "yes," you aren't in compliance with new standards for restraint and seclusion from the Joint Commission on Accreditation of Healthcare Organizations. The standards become effective Jan. 1, 2001. **(See key changes in new standards, p. 154.)**

Restraints are the No. 1 area for Type 1 recommendations, notes **Ann Kobs**, president and CEO of Type 1 Solutions, a Fort Myers, FL-based compliance consulting firm specializing in preparation for Joint Commission surveys.

"Restraint is a very hot public issue," she says. "Therefore, the surveyors will be forced to focus on it."

A hospital receives a score of 1 (total compliance) only if 99% of the restraint orders are time-limited, says Kobs. "The margin for error is slim," she warns.

The standards will be scored for compliance in January 2001, and are not going to be capped, reports **Robert Wise**, MD, vice president of standards at

EXECUTIVE SUMMARY

New standards for restraint and seclusion from the Joint Commission on Accreditation of Healthcare Organizations will become effective Jan. 1, 2001.

- Issues pertaining to restraint and seclusion are the No. 1 cause of Type 1 recommendations.
- Restrain or seclude patients only when there is an imminent risk of physical harm to the patient or others.
- When you are documenting the need for restraint, describe the patient's behavior, not the diagnosis.

the Joint Commission. "This is because of patient safety issues and the known deaths associated with restraint use," he explains.

Although new standards are generally "capped" for compliance to give facilities time to prepare, the restraint standards will be scored immediately, notes **Kathleen Catalano**, RN, JD, senior consultant to the Greeley Co., a health care professional consulting firm in Marblehead, MA, specializing in regulatory compliance.

Usually, Type 1 recommendations build on information gathered across the organization, Catalano says. "However, with restraints, just one 'PRN' order could do it," she adds.

During surveys, ED staff will almost definitely be asked about restraint, says Catalano. "And this topic will be more under fire than usual because of the changes in the standards by both HCFA [Health Care Financing Administration] and Joint Commission," she warns. **(See story on differences between the HCFA and Joint Commission standards, p. 152; and controversy over the one-hour rule, p. 153.)**

ED staff are at higher risk

ED staff are at high risk for noncompliance because there is a tendency to place patients in restraints when it's not truly necessary, warns Wise. "If restraints are used because the ED is crowded or short-staffed, surveyors will take that very seriously," he stresses. **(See story on use of medical/surgical or behavioral health standards in the ED, p. 153.)**

Here are ways to ensure compliance with the Joint Commission's new restraint and seclusion standards:

• **Only use restraint when there is a clear risk of harm to the patient or others.** Use restraints or seclusion only under one circumstance: when there is imminent risk that patients will physically harm themselves or others, according to the new standards. "Even in that case, you should only use restraints as an absolute last resort," says Wise.

Use restraint or seclusion only when nonphysical methods are ineffective or not viable, stresses **Carrie McCoy**, PhD, MSPH, RN, CEN, associate professor of nursing at Northern Kentucky University in Highland Heights, KY. "Do not base use of restraints solely on previous history of dangerous behavior."

The way you document needs to address those criteria directly, stresses Wise. "You need to demonstrate the specific reasons that a patient is in restraint, and show that the risk of harm to self or others reaches the level of imminent danger," he says. "The key is to show that you are not using restraints for convenience or because you are short on staff."

• **Provide staff with training.** Staff should have ongoing education regarding restraint use, says Wise. The training should address the following:

— aggressive behavior stemming from underlying causes such as medical conditions and staff interventions;

— ways to de-escalate patients;

— ways to recognize when a patient is ready for discontinuation of restraint or seclusion;

— signs of physical distress.

There are four training requirements for staff under the Joint Commission standards, says Catalano. "What staff are allowed to do will be dependent on which training requirements they have mastered," she adds. Here are the four levels:

1. A = training requirements for all direct care staff;
2. B = training requirements for staff who are authorized to physically apply restraint or seclusion;
3. C = training requirements for staff who are authorized to perform the 15-minute assessments;
4. D = training requirements for staff who are authorized to initiate restraint or seclusion and/or perform evaluations and re-evaluations.

• **Monitor patients closely.**

You need to assess patients at the initiation of restraint, and every 15 minutes thereafter, says McCoy. Your assessment should include the following, she recommends:

— injury associated with the restraint;

— nutrition/hydration;

— circulation and range of motion to the extremities;

— vital signs;

— hygiene and elimination;

— physical and psychological status and comfort;

— readiness for discontinuation of restraint or seclusion.

Someone should watch the patient for distress at all times, says McCoy. Continuous monitoring is required, in addition to checks every 15 minutes, she stresses.

Wise acknowledges that it's not easy to keep a constant eye on a restrained patient in a busy ED. "But

SOURCES AND RESOURCE

For more information on the Joint Commission's new restraint and seclusion standards, contact:

- **Kathleen Catalano**, RN, JD, The Greeley Co., 1328 Stonecrest Drive, Coppell, TX 75019. Telephone: (972) 393-3336. Fax: (972) 462-7079. E-mail: kathijoe@worldnet.att.net.
- **Ann Kobs**, President/CEO, Type 1 Solutions, 166 S.E. 18th Terrace, Suite A, Cape Coral, FL 33990. Telephone: (941) 574-8318. Fax: (941) 574-8814. E-mail: aejbbk@aol.com.
- **Carrie McCoy**, PhD, MSPH, RN, CEN, Associate Professor of Nursing, Department of Nursing, 346 AHC, Northern Kentucky University, Highland Heights, KY 41009. Telephone: (859) 572-6541. Fax: (859) 572-6098. E-mail: mccoy@nku.edu.

The complete restraint and seclusion standards are available on the Web site for the Joint Commission on Accreditation of Healthcare Organizations (www.jcaho.org). Double click on "For Health Care Organizations and Professionals." Under "Future Standards," click on link to the restraint and seclusion standards. The manuals that include the standards can be purchased by calling the Joint Commission's Customer Service Center at (630) 792-5800, between 8 a.m. and 5 p.m. CST weekdays.

that is a strong incentive to remove the individual from restraints as quickly as possible," he adds. "If a patient in restraints is left alone for a significant length of time, that would be viewed as a serious issue."

Document the monitoring of circulation, color, toileting, and nutrition, says Kobs. "If you perform checks every 15 minutes, then there needs to be documentation that it was done every time," she stresses. "If it isn't documented, it isn't done." **(See items that you need to document, at right.)**

• **Describe the patient's behavior.** Instead of writing a diagnosis such as "overdose" or "altered consciousness" on a patient's chart, describe the behavior instead, advises Wise. Justify restraint use based on those criteria, he stresses. An example would be "restraints are needed to prevent the patient from dislodging tubes," says Wise.

• **Follow protocols to the letter.** Be ready to answer surveyor's questions about your restraint policy and procedure, Catalano advises. "You must be able to regurgitate word for word. You must know what training you've had and if you have been involved in any performance improvement activities for monitoring restraint or seclusion," she says.

Organize your policy and procedure with the following four sections, recommends Catalano:

— philosophy;
— alternatives to restraint/seclusion use;
— clinical justification for restraint/seclusion;
— restraint/seclusion specifics.

All restraint policies should contain the following, according to Catalano:

— a statement that says, "The goal of _____ hospital is to have a restraint-free facility";
— a list of alternatives to restraint use;
— what constitutes clinical justification;
— specific procedures for restraint. ■

Here's what you need to document

Document carefully for each episode of restraint or seclusion using the hospital's restraint stamp or form, advises **Kathleen Catalano**, RN, JD, senior consultant to the Greeley Co., a health care professional consulting firm in Marblehead, MA, specializing in regulatory compliance.

"There should be space for why restraint was necessary, what alternatives were tried, clinical justification, type of restraint to be used, and the time," she says.

Include the following information, advises Catalano:

• the circumstances that led to the use of restraint;
• consideration or failure of nonphysical interventions;
• the rationale for the type of physical intervention selected;
• notification of the individual's family, when appropriate;
• written orders for use;
• behavior criteria for discontinuation of restraint or seclusion;
• informing the individual of behavior criteria for discontinuation of restraint or seclusion;
• each verbal order received from a licensed independent practitioner;
• each in-person evaluation and re-evaluation of the individual;
• 15-minute assessments of the individual's status;
• assistance provided to the individual to help him or her meet the behavior criteria for discontinuation of restraint or seclusion;

• continuous monitoring;
• debriefing of the individual with staff;
• any injuries that are sustained and treatment received for those injuries. ■

Joint Commission's, HCFA's standards now match

The new standards for restraint and seclusion from the Joint Commission on Accreditation of Healthcare Organizations are now much closer to those of the Health Care Financing Administration (HCFA), notes **Kathleen Catalano**, RN, JD, senior consultant to the Greeley Co., a health care professional consulting firm in Marblehead, MA, specializing in regulatory compliance.

The new Joint Commission standards will become effective Jan. 1, 2001, and HCFA's became effective in August 1999. Where the standards differ, your policy should always state the stricter requirement, urges Catalano.

In July 2000, HCFA issued interpretive guidelines for state surveyors to help enforce the new regulations for patient restraint and seclusion, notes Catalano. **(See sources box for how to obtain a copy of the guidelines, right.)** The HCFA requirements apply to all hospitals participating in Medicare or Medicaid, regardless of whether they are accredited, says Catalano.

Because restraint is such a heated public issue, the Joint Commission would look very out of step if they were to be more lenient than HCFA, says **Ann Kobs**, president and CEO of Type 1 Solutions, a Fort Myers, FL-based compliance consulting firm specializing in preparation for accreditation surveys. "Last summer, the Office of the Inspector General accused the Joint Commission of being lax and not seriously scoring the standards as deemed status would require," she notes.

Since then, Joint Commission has been working diligently to come into line with HCFA's more stringent standards, Kobs reports. "They don't want to lose deemed status, since that basically would put them out of business," she says.

Here are several issues pertaining to restraint use and how to comply with Joint Commission and HCFA's requirements:

• **The "one-hour" rule for a restraint order.** The Joint Commission has switched to the "one-hour" rule mandated by HCFA for restraint and seclusion of patients under the behavioral health standards, says **Robert Wise**, MD, vice president of standards at the Joint Commission.

SOURCES

The July 2000 *Interpretive Guidelines for Hospital Conditions of Participation for Patient Rights* can be accessed at HCFA's Web site (www.hcfa.gov/quality/4b2.htm).

The interim final rule *for Quality of Care Standards for Hospital Conditions of Participation for Patient Rights*, which addresses restraint and seclusion, is available via the Internet at the Government Printing Office Web site. The address is www.access.gpo.gov. Click on the *"Federal Register"* icon to search for the July 2, 1999 issue. The *Federal Register* is available at many libraries. Copies of the *Federal Register* can be ordered by mail. The cost of each copy is $8. Specify the date of the issue, and include a check or money order payable to Superintendent of Documents. Contact:

- **New Orders**, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Credit card orders may be placed by calling (202) 512-1800; fax: (202) 512-2250.

The HCFA rule says a physician or licensed independent practitioner (LIP) is required to evaluate patients in person within one hour of restraint or seclusion, says Catalano. The Joint Commission is using the one-hour standard in its surveys, as of Sept. 1, 2000, notes Catalano. Previously, the Joint Commission's standards said the order must be obtained within four hours for adults, two hours for adolescents, and one hour for children under age 9.

Because HCFA requires that the one-hour rule must be enforced for hospitals participating in Medicare, the Joint Commission also has agreed to enforce this requirement for hospitals, reports Wise.

"This clears up long-standing confusion between the two standards," says Catalano.

• **In-person evaluation for updated orders.** The HCFA interpretive guidelines say that a physician assistant or nurse practitioner may evaluate restrained or secluded patients, if they are considered licensed independent practitioners under state law, Catalano explains.

The new Joint Commission standards state that the LIP must be contacted after four hours for an updated order, Catalano says. "The attending LIP must be contacted if he or she was not present when the order for the use of restraint was made by an associate or other LIP."

Under Joint Commission standards, this is the time limit for restraint orders when behavioral restraint is

being used, says Catalano:

— four hours for adults;

— two hours for ages 9-17;

— one hour for under age 9.

As of January, the Joint Commission will allow emergency placement of a patient in restraint by a trained individual, notes Catalano. "Then the LIP must see the patient within four hours," she says.

Joint Commission standards require that if a patient is no longer in restraint when the original verbal order expires, the LIP must conduct an in-person evaluation of the patient within 24 hours, says Catalano. "This differs from HCFA," she notes.

The LIP must re-evaluate patients in person at least every eight hours for patients 18 and older, and every four hours for ages 17 and younger, says Catalano. "This differs greatly from HCFA and is the tougher standard," she states.

• **Debriefing.** The Joint Commission standard also requires debriefing of the patient by staff within 24 hours of the episode of restraint use, says Catalano. "HCFA has nothing comparable to this," she notes. "The debriefing is new and must involve the patient/family, staff, and be documented." ■

Enforcing one-hour rule generates controversy

The Health Care Financing Administration's "one-hour rule," which requires physicians to do a face-to-face evaluation of a restrained patient within one hour, is now being enforced by the Joint Commission, reports **Ann Kobs**, president and CEO of Type 1 Solutions, a Fort Myers, FL-based compliance consulting firm specializing in preparation for Joint Commission surveys.

Not all EDs have a physician immediately available to write the order and perform a face-to-face evaluation, Kobs says. "Over 50% of the hospitals in this country have under 100 beds," she notes. "Many of those EDs don't have a physician in-house 24 hours a day."

The one-hour rule for behavioral health has created a lot of controversy in hospitals, Kobs reports. "This creates a culture war, because administration has to make the move to come into compliance," she says. "That means rousting physicians out of their offices or bed to come see a patient for a face-to-face assessment within one hour of applying [with a phone order] restraints."

You might bear the brunt of enforcing this new standard, warns Kobs. "Nurses will probably be stuck with the frustrating task of trying to get those doctors into the ED, and take all kinds of abuse in the process."

Administrators need to take the heat for enforcing this standard, says Kobs. "It's about putting teeth into the policy," she says. "This takes a gutsy CEO and chief of medical staff who enforces getting those folks in there. If they all wimp out, nurses will be caught in the middle."

The hospital CEO doesn't want any physician to leave or upset the board, she notes. "The chief of staff has to herd the physicians into doing something they don't want to do," she says. "This is *not* nursing's issue, so the best thing nurses can do is not own it. Just keep passing this to medicine and administration." ■

Can you still use med/surg standards?

Previously, the Joint Commission on Accreditation of Healthcare Organizations allowed medical/surgical standards to be used for restraint in the ED, says **Kathleen Catalano**, RN, JD, senior consultant to the Greeley Co., a health care professional consulting firm in Marblehead, MA, specializing in regulatory compliance.

"The ED was allowed to treat restraint the same way as it was treated on the regular nursing units," she says. "That's no longer the case as of Jan. 1, 2001."

Now, as with the Health Care Financing Administration (HCFA), the more stringent behavioral restraint requirement applies wherever the patient happens to be if the patients are aggressive, combative, or at risk of harming themselves or others, says Catalano. "Thus, in the ED, if a patient is at risk of harming anyone, the behavioral standards apply and must be followed," she says. "As of Jan. 1, 2001, the medical/surgical restraint standards no longer apply in the ED for this type of patient."

The new standards require that behavioral health standards be used for those patients, says Catalano. "Now, a patient who is combative, aggressive, unmanageable, or a danger to himself, herself, or others, will be placed in restraint under the behavioral health standards," she explains.

Previously, Joint Commission allowed nurses to initiate restraint and get an order after the fact, Catalano explains. "Under the old standard, the physician had to be notified within 12 hours of initiation of restraint, and the order had to be signed by the physician within 24 hours," she says.

Now, HCFA and Joint Commission say that a patient who is aggressive, combative, or a danger to himself, herself, or others will require behavioral restraint, says

Here are key changes in restraint standards

New restraint and seclusion standards from the Joint Commission on Accreditation of Healthcare Organizations include the following changes:

• Staff are trained and competent to minimize the use of restraints and seclusion, and in their safe use. Staff must demonstrate an understanding of the factors that influence behavior that might result in the need for restraints and seclusion.

• All individuals placed in restraints or seclusion, regardless of age, must have an order for restraints and seclusion issued by a licensed independent practitioner within one hour of the initiation of the restraints or seclusion.

• The length of the initial and any subsequent order for restraints and seclusion cannot exceed a range of one hour for children under age 9 to four hours for adults.

• Upon expiration of an order for restraints or seclusion, a new order — written or verbal — must be issued by a licensed independent practitioner within a range of every one hour for children under age 9 to every four hours for adults. ■

Catalano. "This means that a trained individual must assess the patient and evaluate the need for restraint."

Under the Joint Commission and HCFA standards, it doesn't matter where the behavior occurs, says Catalano. "Any patient behavior that is violent and aggressive and causes the patient to be a danger to himself, herself, or others is considered behavioral. So regardless of where the behavior occurs, restraint use will be treated as behavioral," she says.

Formerly, "behavioral health" referred to a place, a psychiatric unit, a psychiatric hospital, says **Ann Kobs**, president and CEO of Type 1 Solutions, a Fort Myers, FL-based compliance consulting firm specializing in preparation for accreditation surveys. "Now, in concert with the Patients Rights Act, the term refers to behavior, regardless of location," she says. "That is, behavior that endangers self or others."

The medical/surgical standards still can be used for patients who are not aggressive, combative, or dangerous to themselves or others, says Kobs. "Often, patients come in who are pleasantly confused. They may have no idea where they are, but they are not aggressive," she explains. "They forget what you tell them, for example, don't get off this cart, and they try to get off and wander around."

Here are examples of when each standard should be used, from HCFA's *Hospital Interpretive Guidelines for Patient Rights*:

• **Behavioral management standard.** A restraint or seclusion for behavior management is used only as an emergency measure and is reserved for those occasions when severely aggressive or destructive behavior places the patient or others in imminent danger. While different factors may precipitate that type of psychiatric, behavioral, and physical outburst for an individual patient, the need for rapid assessment and continuous monitoring is applicable in each case.

Example: A patient with Alzheimer's disease has a catastrophic reaction where he/she becomes so agitated and aggressive that he/she physically attacks a staff member. The patient cannot be calmed by any other mechanisms, and the behavior presents a danger to him/herself, staff, and other patients.

• **Medical and surgical care standard.** Restraint used for acute medical and post-surgical care, and where the hospital wishes to restraint a patient to address the risk of a fall or to control wandering, falls under the medical and surgical care standard. This standard is used to restrain nonviolent, nonaggressive, otherwise cooperative patients.

Example: A patient diagnosed with Alzheimer's disease has surgery for a fractured hip. Staff determine that it is necessary to immobilize the hip to prevent reinjury. The use of less restrictive alternatives have been evaluated or were unsuccessful. ■

Do patients read your educational tools?

To have success in getting your patients to read discharge instructions and educational materials, it isn't enough to make sure the material is accurate and up-to-date, says **Jean Proehl**, RN, MN, CEN, CCRN, immediate past president of the Emergency Nurses Association, based in Des Plaines, IL.

"Reading level, font size, appearance, and illustrations all need to be considered," she stresses. **(See sample patient education sheets on fractures, injury prevention for older adults, abdominal pain, domestic violence, grief, congestive heart failure, and ED discharge instructions, inserted in this issue).**

Here are ways to make your patient educational materials more effective:

• **Avoid pages of solid print.** Include white space in

EXECUTIVE SUMMARY

Consider reading level, font size, appearance, and illustrations when developing patient education materials.

- Emphasize important points by highlighting them.
- Use illustrations, personal stories, and white space in educational materials.
- Include the patient's name on the front page of educational materials.

the materials you develop, so patients aren't overwhelmed by pages of text, recommends **Jean R. Moss**, PhD, RN, PNP, patient education specialist at Dartmouth-Hitchcock Medical Center in Lebanon, NH. "Illustrations and personal stories are also recommended, because they are more interesting than 'just the facts,'" she says.

• Gather materials from organizations. There is a wealth of material available on injury prevention and management of specific diseases, says Proehl. "Almost all of the associations have patient information pertinent to their mission," she notes. **(See sources and resources box for more information, p. 156.)**

Some vendors also supply written patient education materials and videotapes specific to their products, notes Proehl. For example, Dermabond, a topical skin adhesive manufactured by Ethicon in Somerville, NJ, has a discharge sheet. Lovenox (enoxaparin sodium) manufactured by Aventis Pharmaceuticals, based in Collegeville, PA, has a patient video. And EpiPen, an autoinjector drug delivery system to treat anaphylaxis manufactured by Dey Laboratories in Napa, CA, has a video and training pens for practice.

"However, I always evaluate this material before we put it into place," Proehl says.

• Address needs of non-English-speaking patients. First, translate your most commonly used information sheets into the prevalent languages for your area, says Proehl. "However, in some ethnic groups, literacy in their own language is not the norm," she cautions. "The original Hmong refugees did not even have a written language when they came over in the early 1980s."

Translating the sheets is the easy part, says Proehl. "The tough part is verifying that the patient understands the information on the sheet," she explains. "You frequently need a translator for this."

Language Line Services, based in Monterey, CA, is an excellent resource if you don't have ready access to appropriate translators, Proehl recommends. The line provides 24-hour access to translators in 144 languages, she notes. [To subscribe or use the service periodically, call (800) 752-0093.]

Cultural assessment is also important when deciding on the discharge plan of care, says Proehl. "Maybe there is something from their native culture that can be integrated with the Western plan of treatment. That will increase the likelihood of compliance," she suggests.

If patients seem uncomfortable with a treatment or discharge plan, find out why, recommends Proehl. "Perhaps there is something in the Western plan of care that is unacceptable to the patient/family, so you'll need to come up with an alternative."

• Consider your patient population. When developing materials for education, consider the reading level of your "audience," says Moss. "You would use different materials for an inner-city hospital with a predominantly low-income population than the population for a medical center in a college town."

Members of your target audience should be on the committee that develops those materials, Moss urges. "Also, use another group of the same audience to review the final draft before the pamphlet or videotape is produced."

Members of the target audience should also be on the committee that approves purchased materials, says Moss.

• Provide verbal explanations. It's ineffective to hand a patient a pamphlet or have them view a videotape without any explanation, says Moss. "All materials should have someone who can evaluate the patient's understanding and answer questions," she advises. "A human contact is necessary for the best teaching."

• Direct patients to the Internet. There is a wealth of free material on the World Wide Web, says Moss. "But you have to know the best resources," she notes. Here are three consumer education sites she recommends:

— **www.drkoop.com.** This comprehensive collection of health and disease information is endorsed by former Surgeon General C. Everett Koop, MD.

— **www.healthfinder.gov.** This gateway to selected consumer health information is provided by local, state, and federal government agencies; not-for-profit organizations; and universities. The Web site is a service of the Department of Health and Human Services.

— **www.healthtouch.com.** This collection of on-line pamphlets and other information is from reputable sources such as health advocacy organizations and federal agencies.

• Use highlighters to emphasize important points. If you give patients four pages of information, use highlighter pens for the points they must know, recommends **Margaret M. Duffy**, RN, EdD, CNN, former clinical educator at Medical University of South Carolina

(Continued on page 157)

For more information about patient education materials, contact:

- **Margaret M. Duffy**, RN, EdD, CNN, 304 Stratford Drive, Summerville, SC 29485. Telephone: (843) 871-7052.
- **Jean Proehl,** RN, MN, CEN, CCRN, Dartmouth-Hitchcock Medical Center, Emergency Department, One Medical Center Drive, Lebanon, NH 03756. Telephone: (603) 650-6049. Fax: (603) 650-4516. E-mail: jean.proehl@Hitchcock.org.
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Patient Education Management, a monthly newsletter from American Health Consultants, publisher of *ED Nursing,* is a source for concrete, "how-to," hands-on management information on patient education. Each month, readers receive usable tips from patient education managers across the country detailing how they created and implemented successful education programs — and detailing their mistakes, so you don't have to learn the hard way. With every monthly issue, you'll receive a sample patient education protocol, policy, checklist, or other valuable document that you can tailor to your program without reinventing the wheel. The cost is $365. To order, contact:

- **American Health Consultants**, Customer Service, P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. Fax: (800) 284-3291. E-mail: customerservice@ahcpub.com. Web site: www.ahcpub.com.

Patient education brochures are available from the National Heart Lung and Blood Institute. The publications can be downloaded at no charge from the Web site (www.nhlbi.nih.gov/about/nhaap/index.htm). Or to order, contact:

- **National Heart, Lung, and Blood Institute Information Center**, P.O. Box 30105, Bethesda, MD 20824-0105. Telephone: (301) 592-8573. Fax: (301) 592-8563. E-mail: NHLBIinfo@rover.nhlbi.nih.gov.

Mosby's *Emergency Department Patient Teaching Guide 1* and *Guide 2* are a compilation of more than 200 patient teaching handouts in a binder organized by body system. The handouts are designed for the health care provider to copy and give to the patient and/or family. The product is $74.95. To order, contact:

- **Mosby**, 11830 Westline Industrial Drive, St. Louis, MO 63146-3318. Telephone: (800) 426-4545 or (314) 545-2522. Fax: (800) 535-9935 or (314) 579-3357. E-mail: customer.support@mosby.com. Web site: www.mosby.com.

The National Highway Traffic Safety Administration has age-specific injury prevention sheets that deal with motor vehicle, bicycle, and pedestrian safety. All fact sheets and brochures can be accessed from the Web site (www.nhtsa.dot.gov). Single copies are free and can be duplicated for distribution. For more information, contact:

- **National Highway Traffic Safety Administration**, 400 Seventh St. S.W., Room 5119, Washington, DC 20590. Telephone: (202) 366-5399. Fax: (202) 493-2062. E-mail: kklass@nhtsa.dot.gov.

The American Academy of Pediatrics has a comprehensive, age-based program of injury prevention information. Also, the Academy has public education brochures are available in pads of 100. The cost is $34.95 plus $7.50 shipping and handling. Topics include febrile seizures, poisonings, prevention of shaken baby syndrome, and allergies. A patient education CD-ROM resource has 100 pediatric health care brochures. The cost is $295 plus $29.50 for shipping and handling. For more information, contact:

- **American Academy of Pediatrics**, P.O. Box 747, Elk Grove Village, IL 60009-0747. Telephone: (888) 227-1770 or (847) 434-4000. Fax: (847) 228-1281. E-mail: pubs@aap.org. Web site: www.aap.org.

Helios Health provides Internet "e-stations" free of charge to hospitals for placement in their waiting rooms. Each station has a live Internet connection with video, audio, and animation clips to give patients health-related on-line information. For more information, contact:

- **Helios Health**, 4151 Ashford Dunwoody Road N.E., Suite 610, Atlanta, GA 30319. Telephone: (877) 9HELIOS or (404) 303-2300. Fax: (404) 303-2323. E-mail: ksmith@helioshealth.com. Web site: www.HeliosHealth.com.

Medical Center. Those points may include how many pills to take, when to take them, and what symptoms should prompt a call to the ED, she says.

• **Include the patient's name.** Leave a space on the front page of educational materials for the patient's name, suggests Duffy. "If you put their name on the material, they are not as likely to throw it away," she says. ■

Assess patients' reading levels

Does it ever seem that patients are ignoring educational materials and discharge instructions? This may be due to an inability to read those materials, according to **Margaret M. Duffy**, RN, EdD, CNN, former clinical educator at Medical University of South Carolina Medical Center in Charleston. "The reading level of your handouts may be way too high for your patient population," she says.

A recent study at Medical University of South Carolina Medical Center's ED found that literacy levels of many adult patients were too low to understand ED discharge instructions.[1] The study found that 29 of 110 patients sampled read at a sixth-grade level or lower, while the patient educational materials used in the ED were at a higher reading level.

Only 50% of patients tested could read at a high school level, and 9% could not read at all, reports Duffy, the study's principal investigator. Of the 26 reading materials used in the ED, only one item was at the eighth-grade level, and the others were more complex. Thus, half of the patients in the sample would only be able to read one of the materials tested, she notes.

"In the ED, you only have one visit to educate patients, so whatever information you give them may be all they are going to have," Duffy says.

Here are ways to ensure patient reading levels are not lower than the educational materials you provide:

• **Assess reading levels of ED patients**. At Medical University of South Carolina, 110 patients were given a literacy test. "We told patients that we needed to develop materials appropriate for them and wanted to know what their reading levels were. Everyone agreed to take the test," says Duffy.

The Rapid Estimate of Literacy in Medicine (REALM) test was used to determine patient reading levels. The test can be completed in 90 seconds, says Duffy. The REALM measures a patient's ability to pronounce medical terms in ascending order of difficulty and consists of three columns of 22 words each. The patients were asked in private, behind a curtain, or in the treatment room to read the words in each column. **(See REALM test, inserted in this issue.)**

"The test is quick and easy to score," says Duffy.

Test patients from different times and days to determine the general reading level of the group, recommends Duffy.

• **Use materials geared toward lower reading levels.** Medical University at South Carolina Medical Center has developed a Web site with 250 patient education materials that are all at the 6th to 8th grade reading level, Duffy reports. They are available at no charge (www.musc.edu/medcenter/education/cpeducation).

The reading level of the materials have been evaluated by Prose: The Readability Analyst, manufactured by MicroBrothers Software in Boulder, CO. The reading grade level is listed next to the material, Duffy says.

• **Keep it simple.** Any materials that use jargon or too many undefined medical terms are ineffective, says **Jean R. Moss**, PhD, RN, PNP, patient education specialist at Dartmouth-Hitchcock Medical Center in Lebanon, NH. "Avoid written materials that go into too much detail," she says. "Think about what the patients needs to know, not what is nice to know. A pamphlet packed with text will probably not be read."

Too much information can be intimidating, especially for patients with marginal reading skills, says **Jean Proehl,** RN, MN, CEN, CCRN, immediate past president of the Emergency Nurses Association, based in Des Plaines, IL. "We need to focus on the most important information to get them through the next few days. Complex teaching on anticoagulants or diabetes management is best left for a future date."

ED patients are stressed and not in the best frame of mind to absorb complicated material and psychomotor skills (such as self-injection of medications), notes Proehl. "This has really become a problem with the recent surge in home treatment of deep venous thrombosis with injectable anticoagulants," she notes.

SOURCE

The Rapid Estimate of Adult Literacy in Medicine test and an administration manual is available for $50, including shipping and handling. To order, contact:

- **Terry Davis**, PhD, Department of Medicine, Louisiana State University Health Sciences Center, 1501 Kings Hwy., Shreveport, LA 71130. Telephone: (318) 675-5813. Fax: (318) 675-4319. E-mail: tdavis1@lsumc.edu.

For more advanced education, try to arrange follow up through a home health agency, Moss suggests. "Or call the patients at home to make sure they are following instructions and to answer any questions," she says. "If they are unable to follow through, encourage them to call their family physician for an appointment."

• **Offer a range of materials.** If possible, put a wide variety of educational materials in a display area, suggests Duffy. "If the patients have a range of materials to choose from, they are more apt to pick the one they can read," she says.

Reference

1. Duffy MM, Snyder K. Can ED patients read your patient education materials? *J Emerg Nurs* 1999; 25:294-297. ■

Wei HG, Camargo CA. Patient education in the emergency department.* Acad Emerg Med *2000; 7:710-717.

Patient education in the ED is effective, yet requires specific ED-based approaches, according to this study from the Weill Medical College of Cornell University in New York City, and Massachusetts General Hospital and Brigham and Women's Hospital, both in Boston. The researchers evaluated clinical studies that assessed patient education in the ED and comparable acute care settings.

Here are some of the findings:

• Asthma education results in significant reduction of hospitalizations, ED visits, unscheduled visits to the doctor, and days missed from work and school.

• Chronic heart failure patients who received comprehensive education had fewer readmissions for heart failure and better improvements in quality of life.

• Patients with psychiatric disorders who received educational interventions had improved medication compliance.

The researchers recommend that ED managers take the following steps:

• Target efforts toward high-risk patients for focused patient educational efforts (for example, patients intubated for asthma and substance abusers).

• Use computer-based identification of high-risk patients.

• Customize discharge instructions according to patient age.

• Assess the reading levels of written educational materials by using validated literacy scales.

Many ED patients might not have access to formal patient education anywhere else, the researchers argue. "This becomes particularly relevant when patient education can improve outcomes in chronic illnesses with preventable acute episodes necessitating ED visits," they say and add that more research is needed to provide evidence for effective approaches designed specifically for EDs. ▼

Boudreaux ED, Clark S, Camargo CA. Telephone follow-up after the emergency department visit: experience with acute asthma.* Ann Emerg Med *2000; 35: 555-563.

Although contact rates for follow-up telephone calls to asthma patients were high, certain groups of patients were more likely to be reached, according to this study.

The researchers were from the Earl K. Long Medical Center in Baton Rouge, LA, and Massachusetts General Hospital and Brigham and Women's Hospital, both based in Boston. They interviewed 1,874 adult and 1,184 pediatric patients in the ED. Of those, 1,308 adult patients and 1,026 pediatric patients were successfully reached for a two-week telephone follow-up.

Pediatric patients were more 2.5 times likely to be reached than adults. Patients who were black, low in socioeconomic status, lacking a primary care provider, and smokers were significantly less likely to be reached.

Because there were high contact rates overall, with a median of two calls to reach each patient, telephone follow-up for asthmatic patients is feasible, say the researchers. National Asthma Education and Prevention Program guidelines recommend a follow-up visit with the primary care provider within three to five days of an ED visit, but that may be impractical, unnecessary, or impossible for many patients, they write.

"Telephone follow-up may represent an effective and efficient alternative means of monitoring health," they add.

The researchers recommend the following as possible options to improve contact rates:

• provide a more in-depth rationale to patients for telephone calls, such as explaining the importance of follow-up care;

• make a greater number of attempts;

• obtain a current telephone number at every visit to update registration data;

• tailor callback times to maximize

likelihood of contact;
- solicit best times to call;
- obtain alternate numbers;
- call after working hours. ▼

Natsch S, Kullberg BJ, Meis JF, et al. Earlier initiation of antibiotic treatment for severe infections. **Arch Intern Med** ***2000; 160:1,317-1,320.***

Delays in administering antibiotics to patients can be reduced by using educational interventions combined with clinical practice guidelines, according to this study from the departments of internal medicine and medical microbiology at the University Hospital Nijmegen in the Netherlands.

Guidelines were developed to improve timely antibiotic administration in order to speed diagnostic and therapeutic actions. Educational programs were developed, and lectures given to the medical and nursing staff. Availability of antibiotics was improved in the ED.

Together, those interventions resulted in a substantial quality improvement in the process of care, say the researchers, who recommend the following interventions:

- Keep nurses and doctors informed about delays in antibiotic administration.
- Use clinical guidelines to manage patients with presumed serious infections and on ordering immediate treatment.
- Use guidelines on obtaining cultures for microbiological analysis.
- Inservice the medical and nursing staff about the guidelines.
- Make antibiotics more available by storing them in a readily accessible place.

Groups of 50 patients were evaluated before and after the interventions were implemented. Here were key findings:

- The median time to the initial dose of antibiotics administered decreased from five hours to 3.2 hours.
- The percentage of sputum cultures obtained increased from 28% to 50%, and the percentage of urine cultures obtained increased from 50% to 100%.
- The percentage of patients whose first dose of antibiotic was delayed until a routinely scheduled drug distribution round decreased from 54% to 32%.

The researchers conclude that "coordination of care in the ED and on the inpatient unit with contributions from the pharmacy and the laboratory is needed to reduce the time to initiate antibiotic treatment." ■

Make X-rays easier for trauma patients

Elevate trauma patients on "blocks" on their stretchers so their X-rays can be done easier and quicker, recommends **Darlene Matsuoka**, ED clinical nurse educator at Harborview Medical Center in Seattle. The initial "trauma series"(including chest, pelvis, and lateral cervical spine) are done at the bedside on the patient's ED portable stretcher, says Matsuoka.

"We use two 'trauma blocks'; one at the head of the bed and one at the foot, to elevate the backboard off

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Editorial Questions

For questions or comments, call Joy Daughtery Dickinson at (912) 377-8044.

ED Nursing™ (ISSN 1044-9167) is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA. POSTMASTER: Send address changes to ED Nursing™, P.O. Box 740059, Atlanta, GA 30374-9815.

ED Nursing™ is approved for approximately 18 nursing contact hours. This offering is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses' Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

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the stretcher," she explains.

The trauma blocks, which are 6" x 6" x 36" each, are placed on the stretcher before the patient's arrival. The X-ray films are slid into the gap between the stretcher and the backboard, says Matsuoka. "The blocks are removed when the films are done," she adds.

For a computed tomography (CT) scan, a slider board is placed on the CT table, and staff place the backboard on top of the slider board. "Rather than needing further lifting to position the patient in the scanner, the tech just 'slides' the backboard on the slider board — less friction and work!" says Matsuoka. "This allows one or two people to continue the actual positioning, rather than the three or four people that are often needed. *[Editor's note: Harborview Medical Center plans to patent a product based on this idea. For more information, contact Darlene Matsuoka, RN, BSN, CEN, CCRN, Harborview Medical Center, Emergency Department, Mail Stop 359875, 325 Ninth Ave., Seattle, WA 98104. Telephone: (206) 731-2646. Fax: (206) 731-8671. E-mail: dmatsuok@u.washington.edu.]* ■

CE objectives

After reading this issue of *ED Nursing,* the CE participant should be able to:

1. Identify clinical, regulatory, or social issues relating to ED nursing. (See *Warning! Surveyors won't hold back in evaluating new restraint standards, Assess patients' reading levels, Can you still use med/surg standards?* and *Journal Reviews* in this issue)
2. Describe how those issues affect nursing service delivery.
3. Cite practical solutions to problems and integrate information into the ED nurse's daily practices, according to advice from nationally recognized experts. ■