AMERICAN HEALTH CONSULTANTS

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For Nurse Managers, Education Directors, Case Managers, Discharge Planners

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Bone loss is inevitable with aging, but osteoporosis doesn't have to be

Build strong foundation before age 30

Osteoporosis, or porous bone, is not a natural part of the aging process, as so many Americans believe. It is a preventable and highly treatable disease.

"As you get older, it is normal to lose some bone, but the severe bone loss associated with osteoporosis is not a normal condition," says **Lynn Chard-Petrinjak**, senior communications coordinator for the National Osteoporosis Foundation in Washington, DC.

Bone mass is built until approximately age 30, and then as part of the natural aging process, bones begin

EXECUTIVE SUMMARY

In June, *Patient Education Management* launched a new series on health screenings with an article on prostate cancer screenings. Subsequent issues covered blood pressure, cholesterol, and blood glucose screenings. In our final article in the series, we focus on osteoporosis screenings. The only way to uncover osteoporosis in the early stages of the disease is by conducting a bone mineral density test, because there are no warning signs until someone breaks a bone. Screenings can provide an opportunity to help educate women about prevention and treatment of osteoporosis.

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COMING IN FUTURE ISSUES

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to break down faster than new bone is formed. Therefore, a healthy lifestyle that builds strong bones before age 30 and keeps bones strong later in life is the best method for preventing osteoporosis. The foundation recommends an across-the-life span approach to health that includes a well-balanced diet with at least 1,200 mg of calcium and vitamin D, weight-bearing exercise, and avoiding tobacco and excessive alcohol.

Education about nutrition, activity, and lifestyle choices should target girls as young as 10 years old, says **Felicia Cosman**, MD, clinical director for the National Osteoporosis Foundation. Cosman also is an osteoporosis specialist at Helen Hayes Hospital in West Haverstraw, NY, and associate professor of medicine at Columbia University in New York City. While adult women need to know these same preventive measures, they also need to understand the risk factors and who should be tested. If they have the disease, they need to be taught the treatment options, says Cosman.

Who is at risk? Women are more at risk than men. In fact, 80% of those diagnosed with osteoporosis are women. In America, about 8 million women and 2 million men have osteoporosis, according the National Osteoporosis Foundation. Other risk factors include a thin or small frame, advanced age, a family history of osteoporosis, being postmenopausal, abnormal absence of menstrual periods, anorexia or bulimia, an inactive lifestyle, cigarette smoking, a diet low in calcium, use of certain medications such as steroids, and excessive alcohol use.

The only way to determine whether a person has osteoporosis is by administering a bone mineral density (BMD) test. There are several machines used for testing, but the two main types are central machines, which measure bone density in the hip, spine, and total body; and peripheral machines, which measure bone density in the finger, wrist, kneecap, shin bone, and heel. "Osteoporosis screening is exceedingly important. You can't tell that you have the disease in its early stages unless you get a bone density test," says Cosman.

Don't wait until symptoms appear

Women between the ages of 50 and 65 should get a BMD test if they have any of the known clinical risk factors for osteoporosis, and all women at age 65 and older should be tested. Those treated for osteoporosis should be retested every one to two years, and those in the normal range should consult their physician about when they should

be retested, according to the National Osteoporosis Foundation. "It is important to uncover osteoporosis in the early stages of the disease because there are no warning signs until someone breaks a bone. If it is diagnosed and treated early, a person may never break a bone," says Chard-Petrinjak.

Bone fractures can be debilitating and the two major fractures for people with osteoporosis are of the hip and spine. Only 10%-20% of seniors older than 65 who break their hip are able to resume their former lifestyle once the fracture has healed, says Cosman.

With spine fractures, the bone tends to compress in on itself, and people not only lose height, but the shape of the spine and torso change, explains Cosman. People end up with their head pointing downward, which makes it difficult to walk and they fall more often. Frequently, they have back pain, chronic neck pain, abdominal discomfort, and are at greater risk for dying of pulmonary illnesses such as pneumonia. The spine fractures occur spontaneously just by walking around, reaching for a dish, or turning in bed. "The fractures have a big impact on the quality of life and also life span," says Cosman.

While Cosman advocates testing, she generally is not in favor of public screenings at health fairs. Usually, peripheral machines are used to do the BMD tests, and these are not as accurate as the central machines that measure bone density in the hip, she says. "There is no other test that is as good as the central DXA [Dual Energy X-ray Absorptiometry] test, and I think that sometimes people may be misled by the peripheral test. It is a good test if you don't have access to the central test," explains Cosman.

Another problem Cosman sees with community osteoporosis screenings is that younger women are being tested, which is inappropriate because there are no medications that are available for that young age group. The foundation recommends that postmenopausal women older than 65 are screened, and women older than 50 who have one or more risk factors in addition to being post-menopausal. Sometimes, these young women are traumatized to find out they have very low bone density even though it is within the normal scale, because the bell curve includes people with very low bone density and some with very high. Osteoporosis-related fracture in the young age group is small, says Cosman.

"We shouldn't routinely test pre-menopausal women. Some pre-menopausal women with certain underlying diseases or those taking specific drugs that can adversely affect the skeleton should be tested, but in general we do not advocate testing in that young age group," says Cosman.

There is also the quality control issue. Often at public screenings, people are handed a piece of paper and they have no idea what to do with it. There isn't good follow-up, says Cosman. Yet, she does concede that some health fairs are well run.

Opportunity to get the word out

While people who are not always appropriate candidates due to their age or risk factors take advantage of the screenings at health fairs, their presence provides great opportunities for education, says **Brenda Covert**, RNC, women's services coordinator at Sacred Heart Medical Center in Spokane, WA. "We really want to increase awareness in younger women that osteoporosis is something that you think about now," she says. It is especially important because many young women do not eat well and some have eating disorders. They also tend to drink a lot of soda that has phosphorus, which pulls calcium out of the bone, says Covert.

However, it is important to emphasize that the screenings are a service rather than a diagnostic procedure and are meant to identify people that may be at risk for osteoporosis, says Covert.

The vital part of a community outreach screening is the education and 10-15 minutes spent with each individual for this purpose during the osteoporosis screenings conducted at the University of Missouri Health Care's health information center located in Columbia Mall. "Registered nurses go over the medical history for each individual and their risk factors as well as current methods of prevention and treatment. We work with the state Osteoporosis Education Program and provide lots of handouts," says **Janet Hale**, RN, manager of the health information center in Columbia. People at risk are referred to their physician for follow-up and are given the computer printout from the DXA heel scan.

Education during the osteoporosis screenings conducted by women's services at Sacred Heart Medical Center is both verbal and written, says Covert. Many pharmaceutical companies produce pamphlets on osteoporosis, and these are distributed as well as materials produced by the health care facility in conjunction with its orthopedic department and physicians within the community. These materials cover risk factors and ways to prevent osteoporosis focusing on

SOURCES

For more information about osteoporosis screening, prevention, and treatment, contact:

- **Lynn Chard-Petrinjak**, Senior Communications Coordinator, and **Felicia Cosman**, MD, Clinical Director, National Osteoporosis Foundation, 1232 22nd St. N.W., Washington, DC 20037. Telephone: (202) 223-2226. Web site: www.nof.org.
- **Brenda Covert**, RNC, Women's Services Coordinator, Sacred Heart Medical Center, W. 101 Eighth Ave., Box 2555, Spokane, WA 99220. Telephone: (509) 474-2058. E-mail: covertb@shmc.org.
- **Janet Hale**, RN, Manager, Health Information Center, University of Missouri Health Care, Columbia Mall, 2300 Bernadette Drive, Columbia, MO 65203. Telephone: (573) 882-4743. E-mail: halej@health.missouri.edu.

diet and lifestyle. There is some mention of medications that build bone or prevent bone loss, but for this information, people are told to talk to their pharmacist or health care provider.

If it is a large event and 200 people are being screened each day, there's little time for individual education, says Covert. Written materials are always given, and the results of the screening are explained and people are told if they need to follow-up with their physician, says Covert. However, at most screenings, participants are asked to fill out a brief history that includes questions about their diet, lifestyle, medications they are taking that might put them at risk for osteoporosis such as steroids, and whether they have a physician. The information helps with education and follow-up. Those who don't have a physician are given a list of clinics they can go to.

Women's services at Sacred Heart Medical Center conducts the screenings wherever needed, which include senior wellness conferences, retirement facilities, schools, and corporate health fairs. They also carry the DXA scan machine on the coach they use for medical outreach so osteoporosis screenings can be done at other times.

When screenings are offered at the health information center in Columbia Mall, the promotions recommend that women entering menopause and men over 65 be screened, but anyone can participate. The first time the screenings were offered, 400 people took advantage of them. Now they are offered at the center every three months.

If a person is diagnosed with osteoporosis, the education at the physician's office should include a review of all the available medications, says Cosman. The education process should help the patient make an informed decision by determining what is appropriate based on the individual's personal history, family history, other medical conditions, and personal preferences, she says.

While there are pros and cons to community outreach osteoporosis screening, it does provide an opportunity to draw attention to a disease that is often misunderstood, says Hale. "One pro is that we have people's attention to discuss prevention of osteoporosis and promote healthy lifestyles. The screening brings in people who may not just come in for health teaching," she says. ■

Make culture one piece of pain assessment

Biggest mistake is to generalize

Pain management for a multicultural population need not be difficult, health care professionals simply need to realize that culture and ethnicity are just one part of the pain assessment.

While there are some similarities between ethnic groups, don't generalize, especially when writing pain management guidelines, says **Gloria Juarez**, RN, research specialist at the City of Hope National Medical Center's department of nursing research and education in Duarte, CA.

The way people manage pain also depends on their experience with pain, what they have learned from their family about pain, their socioeconomic status, education, and coping styles. In addition, the amount of stress patients are in at the time, the pain education that is being provided, their motivation to learn, and their anxiety level all impact pain management, she explains.

It's important not to stereotype people according to culture, believing that people of one culture act a certain way with pain, and people from another culture act another way. "The big thing

EXECUTIVE SUMMARY

Patient Education Management is beginning a series of articles on helping health care organizations improve pain management for patients. This month, we focus on the multicultural issues of pain management. When working with multicultural populations, it is important to note that culture is only one factor that influences how a person may handle pain.

with cultural competence is to not stereotype people according to their surname, appearance, or national origin, but to appreciate that people from different cultures may have been taught different meanings of pain. We are taught within our family or cultural framework how we behave when we have pain and also what we do when we have pain," says **Pat Collins**, RN, MSN, AOCN, clinical nurse specialist oncology / pain at Baptist Health System of South Florida in Miami.

It's important for health care professionals to develop a relationship with patients so that they are comfortable enough to talk about what the meaning of pain is to them, says Collins. Ask patients how they were taught to behave when they had pain. For example, were they taught that it was OK to cry or that they should act stoic?

No matter the culture, it is important to assess each person on an individual basis with no preconceived ideas, agrees **Richard Thalmann**, BSRN, CCRN, instructor of nursing at New York Presbyterian Hospital in New York City. That's why the health care facility is redesigning its admission assessment for pain. Patients will be asked for their history of pain, what increases or decreases it, what they do to control pain, either through ice packs, relaxation techniques, or medication, and how well it has worked.

"We want to ask the patients how they have been dealing with pain by the time they get to us because it's important to know how successful they have been," says Thalmann.

Some pain education is universal

While individual assessment is important, there's also some universal teaching that all patients need to know and understand. After working in a burn intensive care unit for 12 years at New York Presbyterian Hospital, Thalmann discovered that people of all cultures should be taught the basics of good pain management and why it is important to a good recovery. The education should include information about when patients should ask for pain medicine and why good pain management is important.

They need to understand that it isn't just a matter of comfort, but that there's scientific evidence that shows if pain is not managed well, a patient's length of stay can increase and there can be complications, Thalmann says.[1] If there's a language barrier, an interpreter should be used to make sure that the patient and family members understand the basics of good pain management, he adds.

SOURCES

For more information about multicultural pain management, contact:

- **Pat Collins**, RN, MSN, AOCN, Clinical Nurse Specialist Oncology/Pain, Baptist Health System of South Florida, Miami. E-mail: pcollins@bhssf.org.
- **Gloria Juarez**, RN, Research Specialist, City of Hope National Medical Center Department of Nursing Research and Education, 1500 E. Duarte Road, Duarte, CA 91010. Telephone: (626) 359-8111, ext. 63722. E-mail: Gjuarez @coh.org.
- **Richard Thalmann**, BSRN, CCRN, Instructor of Nursing, New York Presbyterian Hospital, 525 E. 68th St., Box 174, New York, NY 10021. Telephone: (212) 746-1222. E-mail: rthalman@nyp.org.

"A lot of people don't understand that pain medicine is a modality that is part of their recovery just like antibiotics are part of their recovery when they have an infection," says Thalmann. While patients have the right to refuse treatment, it is important that the decision is an informed one.

When working with people who come from a culture that's different from their own, health care professionals should be in a learning mode, says Collins. They should try to learn what worked for pain management in the past and what hasn't worked in terms of their cultural background and life experience. "It is more of a teacher-learner kind of thing where we reverse the roles. I think that is how we can work best with other cultures," says Collins.

In a study on pain, which involved cancer patients of Mexican descent, Juarez found that some patients would downplay the amount of pain they were having because they did not want to worry their family. Therefore, it is often more appropriate to have patients tell about their pain by asking how they feel or if they were able to do the things they usually do each day.

"It isn't always asking how their pain is or if they are having pain. Sometimes, the health care professional needs to ask in a different way. They need to really talk to them and get them to describe their pain and how it affects their day," says Juarez.

Reference

1. Grant M, Ferrell B, Rivera L, et al. Unscheduled readmissions for uncontrolled symptoms: A health care challenge for nurses. *Nurs Clin North Am* 1995; 30:673-82. ■

Group lectures provide facts for behavior change

Must be motivated to get in

When chronic pain sufferers enroll in the outpatient pain management program at the Chronic Pain Care Center of the Rehabilitation Institute of Chicago, they are hoping for a miracle because nothing else has worked.

What they get in the four-week program is a series of group lectures as well as individual work with a physical therapist, occupational therapist, psychologist, and physician. "The pain management program teaches them the tools they can use for the rest of their lives," says **Elizabeth Granfeldt**, RN, CRRN, patient education coordinator at the Chronic Pain Care Center.

Those who enroll in the pain management program usually suffer from chronic low back pain, knee pain, headaches, fibromyalgia, complex regional pain, and myofacial pain syndrome. However, not all chronic pain sufferers are accepted to this program. Every candidate for the program is evaluated, and only those who are motivated to learn and make behavioral changes to control pain are accepted.

Patients have one-month, three-month, six-month, and one-year follow-up appointments when they complete the program where they are evaluated to see if they are putting into practice the things that they were taught. For example, the physical therapist will ask them to demonstrate the exercises they learned.

An important part of the program is a series of educational lectures conducted by nurse educators that cover medication, sleep, sex, nutrition, and laughter. These topics all play a part in pain control and quality of life. The information and tips covered in these lectures include:

- **Medication.**

In this lecture, patients learn about endorphins, the body's natural painkillers. "The body makes these natural painkillers when there are small amounts of pain and stress in a person's life. Endorphins tend to get slowed down by chronic pain, stress, nicotine, caffeine, and long-term use of narcotics," says Granfeldt. Therefore, patients learn how to get their endorphins back or how to increase them; and one of the main ways is through aerobic activity.

Also covered in the lecture is information on how narcotics and non-narcotics work to reduce pain and what some of their side effects are. The philosophy of this program is the fewer narcotics used for chronic benign pain the better. "Most are in this program because the narcotics have failed. I tell patients to save the medicine for the bad times," says Granfeldt.

Instead of using medication, patients use such techniques as pacing skills. For example, rather than mowing the whole lawn, they can mow three strips, go inside and use a heat pack for their pain, and then go mow six strips of grass.

- **Sleep.**

Sleep deprivation increases pain, so patients are taught how to sleep well at night. The lecture covers things that interfere with sleep, such as caffeine and nicotine. It also covers sleep hygiene, which encompasses establishing a regular time to go to bed and wake up; limiting TV watching and reading in bed because they stimulate the brain; and eliminating racing thoughts at bedtime by imagining a big stop sign or writing down the thought in a journal before going back to bed.

During the class, participants also take a bedroom inventory evaluating the lighting, bedding, and other factors that could influence whether they get a good night's sleep.

Unlikely topics part of education

- **Sex.**

Chronic pain often impacts people's sexual activities and therefore their quality of life, which is why the topic is included in the educational lectures. "I emphasize communication and experimentation. People must be willing to talk with their partner and experiment with different sexual techniques and posture. I tell them that almost anything they are learning about therapy they can apply to sex," says Granfeldt. For example, self-massage prevents muscle spasm.

- **Nutrition.**

This lecture covers the importance of eating a good, balanced diet based on the food guide pyramid. Also covered is a discussion of herbs because many people ask about herbs and herbal medicines. The policy of the center is that until there is a double-blind placebo controlled study that shows the value of an herb, the center will not advocate the use of it, says Granfeldt.

- **Laughter.**

Lots of jokes and funny stories are told during this lecture to get participants to laugh. Information on the health benefits of laughter is provided.

SOURCE

For more information about the educational program at the Chronic Pain Care Center, contact:

- **Elizabeth Granfeldt**, RN, CRRN, Patient Education Coordinator, Chronic Pain Care Center of the Rehabilitation Institute of Chicago, 1030 N. Clark, Suite 647, Chicago, IL 60610. Telephone: (312) 238-7885. E-mail: bgranfeldt@rehabchicago.org.

For example, it is good therapy for stress and chronic pain and it improves circulation.

Each discipline at the Chronic Pain Care Center builds on the education provided at the basic lectures. For example, psychology teaches people how to deal with stress, fear of helplessness, and loss of control, which are moods that go along with pain.

"In our program, we treat the whole person, not just back or neck pain," says Granfeldt. ■

'User-friendly' resource centers draw consumers

Engage them with sight, sound, and touch

Resource centers can provide health care consumers information they need to become more informed, help them lead healthier lives, and enable them to make informed decisions. However, these benefits can only be realized if the center is user-friendly.

"Consumer information centers need to be patient-centered and organized with patient needs in mind," says **Carol Maller**, RN, MS, CHES, patient education coordinator at New Mexico Veterans Affairs (VA) Health Care System in Albuquerque. This includes providing enough floor space for physically challenged users to freely move around; shelving materials in such a way that they can easily be found; selecting timely titles that follow current news in the media; having models available that invite the visitor to hold, touch, feel, and experience; and learning stations that engage the user, she explains.

There are many elements that improve "user-friendliness," according to the experts. Following are a few essentials that should be kept in mind when creating a resource center designed for the health care consumer:

• Easy-to-find materials.

Label shelf topics in laypeople's language, advises **Arlen Gray**, MA, family library coordinator at The Family Library of Egleston at Children's Healthcare of Atlanta at Egleston. For example, use heart for the cardiology section and cancer for the oncology section.

Whenever possible, place medical models near the books and videos on the topic, says **Magdalyn Patyk**, MS, RN, coordinator of patient education and nursing development at Northwestern Memorial Hospital in Chicago. For example, place the kidney near the urinary tract section and the heart near the cardiac section. Medical models are great teaching tools, and the resource center at Northwestern Memorial has about 150 of them. "There is nothing like a three-dimensional piece of equipment that you can put your hands around and examine," she explains. **(For information on providing health care consumers with the help they need, see article on p. 117.)**

Health observance months are a great time to familiarize the public with the resources available at the center, says Patyk. Each month, the resource center at Northwestern Memorial has a health theme based on one of the national observances such as Men's Health Month. At that time, the books, journals, models, and other resources on that topic are moved to the front of the center. "It adds interest and highlights the various resources we have," says Patyk. **(For an idea on an observance month to feature, see article on National Drunk and Drugged Driving Prevention Month on p. 117.)**

Multiple copies of pamphlets are arranged on shelves in broad categories so visitors to the resource center at The Ohio State University (OSU) Medical Center in Columbus can easily find them and take one, says **Rebecca Mehling**, MLS, librarian at the resource center. For example, there are eight shelves with cancer pamphlets. One shelf focuses on types of cancers and others on such topics as cancer treatments or the psychological aspects of cancer.

"With our books and videotapes, we use the Library of Congress classification system, which brings all the materials together that are on the same subject," says Mehling.

• Materials the average consumer can understand.

A wide range of information on the major conditions that are treated at either campus of Children's Healthcare of Atlanta are kept on

hand at the consumer library, from the very basic to advanced clinical information. "I have a kids' book of a heart that adults use to find out basic heart function," says Gray. However, she also has clinical textbooks written for physicians that are available for parents who want them.

It's good to stock materials in multiple formats on various levels, says Patyk. At Northwestern Memorial, there's everything from light consumer health information to professional medical journals. "We are primarily electronic, but our center has a lot of books, journals, audiotapes, and videotapes in addition to our multimedia computers."

To make the computers user-friendlier, Internet links are listed by categories on the health learning center home page. When people click on a category, such as treatments and tests, they find Internet links on that topic and each site listed has a description. In that way, it is easy to surf for information, explains Patyk.

Create an information seeker's environment

• An inviting layout.

Pleasant and soothing colors combined with comfortable furniture creates an atmosphere at the resource center at Children's Healthcare of Atlanta at Egleston where parents can relax. This entices parents, often stressed by their child's illness, into the center. Other consumer-friendly elements include a children's play area with lots of toys and child-size furniture as well as resource materials for kids stocked on shelves at their height. A private viewing area makes it easy for parents to view videotapes on personal health topics, says Gray.

Privacy is important, agrees Patyk. At Northwestern Memorial, people have access to private rooms to speak with staff, listen to audiotapes, or watch videos. While most of the 20 computer stations are in open areas, a few have been designed for privacy as well.

• Convenient service hours.

"If the service you are providing is important enough to provide, and if the center is service-oriented, the hours that a center is open does reflect on its user friendliness," says Mehling. The resource center at The OSU Medical Center had split hours Monday through Thursday when it first opened. It was open 10 a.m. to 4 p.m., closed for two hours, and open in the evenings from 6 p.m. to 8:30 p.m. On Friday, the hours were 10 a.m. to 4 p.m., and was closed on the weekends.

SOURCES

For more information about creating a user-friendly resource center, contact:

- **Arlen Gray**, MA, Family Library Coordinator, Family Library of Egleston, Children's Healthcare of Atlanta at Egleston, 1405 Clifton Road N.E., Atlanta, GA 30322. Telephone: (404) 315-2611. E-mail: arlen.gray@choa.org.
- **Carol Maller**, RN, MS, CHES, Patient Education Coordinator, New Mexico VA Health care System, 1501 San Pedro Drive S.E., Albuquerque, NM 87108. Telephone: (505) 265-1711, ext. 4656. E-mail: carol.maller@med.va.gov.
- **Rebecca Mehling**, MLS, Librarian, The OSU Medical Center, The Center for Health Information, 410 W. 10th Ave., Columbus, OH 43210. Telephone: (614) 293-3707. E-mail: mehling-1@medctr.osu.edu.
- **Magdalyn Patyk**, MS, RN, Coordinator, Patient Education, Nursing Development, Northwestern Memorial Hospital, 251 E. Huron, Suite 4-708, Chicago, IL 60611-2908. Telephone: (312) 926-2173. Fax: (312) 926-1741. E-mail: mpatyk@nmh.org.

Statistics kept by staff showed that the center was not being used in the evening. Also, people were requesting access later in the afternoon and on weekends. To meet the needs of the consumers, the hours were changed to Monday through Thursday 10 a.m. to 6 p.m., Friday 10 a.m. to 4 p.m., and Saturday from 10 a.m. to 2 p.m.

When the center is closed, consumers can drop information requests in a box on the outside door or leave them via voice mail or e-mail. "Our goal is to have the information available within 24 hours of the time that it was requested," says Mehling.

• Learning stations that engage the user.

The focus of the Fountain of Healthy Living Learning Center at the New Mexico VA Health Care System is behavioral self-management; therefore, there are many things in place to engage the learner in new behaviors. For example, visitors can have their blood pressure taken via a machine and receive a digital readout. Blood pressure wallet cards are available to record the reading. A video scale allows the user to do a simple computer analysis to determine weight and calorie information.

Also, one personal computer (PC) is a dedicated glucometer station where the consumer can remove the microchip from their glucometer, connect the port to the PC, and follow a set of simple instructions to start the download. A copy of the

results in a pie chart and log is printed for the consumer to take to his or her provider. "If the initial visit to the center is positive, there will be return visits as consumers become more engaged in an active role of caring for themselves and problem solving," says Maller. ■

For best service, ask — then ask again

Get a clear understanding of what they want

People who visit consumer health libraries do not always know what information they are looking for, says **Arlen Gray**, MA, family library coordinator at The Family Library at Egleston, Children's Healthcare of Atlanta at Egleston. Therefore, it's important to take the time to talk with them to determine what information they are looking for, she says.

It is essential to ask the right questions until there's a clear understanding of what the consumer is looking for, agrees **Rebecca Mehling**, MLS, librarian at the health resource center at The Ohio State University (OSU) Medical Center in Columbus. If someone has a new diagnosis, it would be appropriate to begin with a consumer health pamphlet or brochure. However, if the visitor had colorectal cancer and was diagnosed two years ago, he or she would understand the staging and treatments but might find clinical trial information or the latest treatment for stage three colorectal cancer of interest. "We would search the clinical trials databases and research some of the medical literature," advises Mehling.

To determine if material is appropriate, show it to the families and ask if it's what they are looking for, advises Gray. It's also appropriate to name specific web sites and ask if they found them in their search or discuss databases the library subscribes to. "With databases, we have information that parents aren't able to get on their own," she says.

To meet the needs of consumers, it's important to have well-trained, friendly staff, says **Magdalyn Patyk**, MS, RN, coordinator of patient education and nursing development at Northwestern Memorial Hospital in Chicago. Everyone who comes through the door of the resource center is greeted and asked if they need assistance. When consumers want to browse on their own, staff periodically make rounds to ask if the visitors are finding what they want. "If they want help, we try to target the information they are looking for by asking some probing questions," says Patyk.

Staff training is important to ensure that people receive the information they need and that the staff are sensitive to the clients' needs. Therefore, volunteer training at The OSU Medical Center covers people skills as well as information skills. Volunteers learn telephone etiquette, as well as how to deal with difficult people and people who have emotional issues.

"We talk about the importance of being compassionate and the fact that sometimes just listening with a caring ear is as important as the information provided," says Mehling. Also covered in training is the reference interview and the need to determine the visitor's "real question." ■

Drinking and driving: National health problem

Education key to curbing fatalities and injuries

Drunk and drugged driving is one of America's leading public health problems, says **John Moulden**, MS, president of the National Commission Against Drunk Driving in Washington, DC. "The numbers alone make it an immediate public health problem," he says. In 1999, nearly 16,000 people were killed and more than 300,000 injured as a result of alcohol-related accidents. Anyone who rides in a car is at risk of being hit by a drunk driver, too.

During late November and December when people celebrate Thanksgiving, Christmas, and New Year's, the incidence of drinking and driving goes up, increasing the public's risk of injury. Therefore, December is a time when communities partner with the Washington DC-based National 3D Prevention Month Coalition in a public awareness campaign to prevent drinking and driving.

Education is a key element of National Drunk and Drugged Driving (3D) Prevention Month. Many responsibility measures, such as designated drivers, are a result of victims advocates groups like Dallas-based Mothers Against Drunk Driving who put a face on the problem by telling personal stories. "People realized that drinking and driving wasn't some social faux pas; it was really a crime, and people were getting killed and injured," says Moulden.

Personal responsibility is very important and it is not just teaching the public not to drink and drive, says Moulden. It's important that people learn how to protect themselves from a drunk driver. Defensive measures include wearing a safety belt and being sure that children are properly secured in child safety seats. It's also refusing to ride in a car with someone who has been drinking, but instead opting to call a cab or asking a sober friend for a ride.

To help prevent drunken driving fatalities, people need to learn to be responsible party hosts by having nonalcoholic drinks available and serving food along with alcoholic beverages. It's also important to take the car keys from guests who have had too much to drink and to refuse to serve alcohol to those who are underage for legal drinking.

While driving, people should not hesitate to call law enforcement from a cellular phone or pay phone if they see someone driving erratically, and they should be prepared to provide the license plate number and a description of the car.

Many estimate the number of alcoholic beverages they can have before they will be over the blood alcohol concentration limit in the state where they are driving, yet impairment begins with one alcoholic drink. Also, it's difficult to know when a person is past the limit because the rate of alcohol absorption varies according to a person's height and weight, how much food they have consumed, and their tolerance level for alcohol.

The message the coalition wants to get out is that one drink is too much for anyone who is driving. The reason behind the message is that one drink decreases a person's ability to quickly react.

A group that composes about half the drinking and driving problem are males ages 21-34 years old, which the coalition has made a target. "One of the reasons they are a target is that they are hard to reach," says Moulden.

However, research has shown that employers, wives, and girlfriends have quite a bit of influence on this group. Therefore, the coalition is trying to convince employers to get the message about drinking and driving across to their employees and to make drunk driving a career-influencing offense. Other difficult groups to reach are the hardcore, repeat offenders and youth who are inexperienced at both driving and alcohol consumption.

Health care professionals interested in putting together an educational program for National 3D Prevention Month can send for a folder that contains suggestions for outreach activities. "It has information on how to have a responsible party, individual responsibility tips, understanding blood alcohol concentration, the relation between alcohol ingestion and drunk driving, and partnership ideas," says Moulden. It also has details on how to find out about programs within the community that keep alcohol-impaired people off the road, such as a free cab ride program.

The theme for this year's campaign is the current theme of the Washington DC-based National Highway Traffic Safety Administration — You Drink & Drive, You Lose. ■

SOURCE

For more information about National Drunk and Drugged Driving (3D) Prevention Month, or to obtain a folder of educational ideas for community outreach programs, contact:

- **John Moulden**, MS, President, National Commission Against Drunk Driving, 3D Prevention Month Coalition, 1900 L St. N.W., Suite 705, Washington, DC 20036. Telephone: (202) 452-6004. E-mail: jmoulden@trafficsafety.org. Web site: www.3dmonth.org.

The sense of smell as a healing power

Know about the nose for patients

Most people know the word "aromatherapy." They have wandered the aisles at retail stores examining lotions and candles that have an aromatherapy label. However, chances are these products aren't authentic.

"There is a misconception that any smell will be considered aromatherapy, but aromatherapy is the use of pure and natural essential oils distilled from real plants. It is not synthetic or perfume oils, and they are not created in a laboratory," says **Teshan Laucirica**, a spokeswoman for The National Association for Holistic Aromatherapy (NAHA) in Seattle, and a certified aromatherapist.

Pure essential oils are extracted from various parts of certain plants through steam distillation and other methods. For example, citrus oils are extracted by mechanically cold-pressing the fruit peel. About 300 essential oils and related natural aromatic products can be purchased through specialized sources according to NAHA.

The oils are considered a tool for holistic healing,

SOURCE

For more information about aromatherapy, contact:

- **Teshan Laucirica**, Certified Aromatherapist, The National Association For Holistic Aromatherapy, 4509 Interlake Ave. N., No. #233, Seattle, WA 98103-6773. Telephone: (206) 547-2164. Web site: www.naha.org.

improving health and overall well-being and can be administered in a number of ways. They can be absorbed through inhalation into the bloodstream through the use of such devices as a nebulizer, electric diffuser, or ceramic diffuser, which uses a votive candle to vaporize essential oils that have been dropped onto water. They also can be absorbed through the skin during massage, while taking a bath, or with compresses. Carrier oils, such as grapeseed oil, are used to apply the essential oil to the skin.

"Even if other types of treatments are being used, aromatherapy can be complementary. Some of the most common reasons aromatherapy is sought is for relaxation, colds, flu, and infections," says Laucirica.

Each of the essential oils has attributes that fit specific needs. Lavender is believed to have a relaxing effect that calms anxiety and helps people sleep. Geranium is used to balance mood swings, ease depression, or help relieve the symptoms of premenstrual syndrome.

The oils are extracted from the "essential" part of the plant, thus their name. It is the part of the plant that contains the characteristic aroma and "life force," according to NAHA. However, the oils are only as good as the plants they were extracted from. Quality depends on the geographic location of the plant, the cultivation method, and climate. Distillation techniques also affect the quality of the oils.

To determine which oils to use, an aromatherapist interviews clients gathering information about their physical and psychological health history so he or she can create a personalized blend of essential oils, explains Laucirica. To make sure a blend of oils will suit their needs, people should think about how they feel overall and what issues they want to address before their visit to an aromatherapist. If muscle pain is the main problem, the aromatherapist will create a blend of oils that address the physical pain caused by muscle tension and also address the mental and emotional state that contributes to the muscle tension.

The customized blending of essential oils is called synergy and requires knowledge and skill. "The therapist should have a certificate of a minimum of 200 hours aromatherapy training, have a diploma which is generally 300 hours training, or have national registration, which means the therapist completed and passed the national exam. They also should have some experience," says Laucirica.

Aromatherapy works because the molecules from the essential oil enter the nasal passages and stimulate the olfactory nerve, according to NAHA. The inhalation causes physiological and psychological changes within the body. "People can expect almost instant results, as the sense of smell affects the whole body. Of course, it does depend on what is being treated," says Laucirica.

Aromatherapy is a holistic therapy, so people

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Editor: **Susan Cort Johnson**, (530) 256-2749.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Leslie Coplin**, (404) 262-5534, (leslie.coplin@ahcpub.com).
Managing Editor: **Kevin New**, (404) 262-5467, (kevin.new@ahcpub.com).
Production Editor: **Nancy McCreary**.

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Editorial Questions

For questions or comments, call **Susan Cort Johnson** at (530) 256-2749.

CE/CME Questions

13. Without a bone mineral density test, people do not know they have osteoporosis until they experience a bone fracture.
    A. True
    B. False
14. Pain management depends on several factors; therefore, an assessment should include:
    A. cultural beliefs.
    B. past experience with pain.
    C. coping styles.
    D. all of the above
15. The attributes of a user-friendly resource center include:
    A. topics in lay language.
    B. private rooms for video viewing.
    C. staff who approach visitors only if asked.
    D. A & B
16. When a child with a chronic illness prepares to go back to school, education should cover:
    A. how to answer peer's questions.
    B. coping strategies for pain.
    C. a child's worries or concerns.
    D. all of the above

shouldn't expect to walk into a clinic with an ailment and get a little bottle of "miracle cure," warns Laucirica. The number of sessions varies depending on people's state of health and their willingness to become actively involved in improving their health.

The techniques of aromatherapy can be learned for personal use through books and short courses. However, essential oils should be administered with care because they are highly concentrated and more is not better, says Laucirica. They should never be used undiluted on the skin or taken internally.

Essential oils were used for mental and physical well-being thousands of years ago by the Egyptians, Greeks, Romans, and Chinese. However a French chemist, Rene-Maurice Gattefosse, coined the term aromatherapy in the 1930's. He discovered the healing power of essential oils when he stuck his burned hand into a vat of lavender oil while working at his family's perfume factory. The burns healed within hours.

"The largest misconception about aromatherapy is that people think it is for relaxation and spa purposes only. While it is very effective for these purposes, it is also a very effective form of natural medicine with many uses," says Laucirica. ■

CE objectives

After reading *Patient Education Management*, health professionals will be able to:

- identify management, clinical, educational, and financial issues relevant to patient education;
- explain how those issues impact health care educators and patients;
- describe practical ways to solve problems that care providers commonly encounter in their daily activities;
- develop or adapt patient education programs based on existing programs from other facilities. ■

Focus on Pediatrics
PATIENT EDUCATION MANAGEMENT'S MONTHLY SUPPLEMENT

Teaching CPR a must in critical cases

Overcome barriers, emphasize practice for success

Cardiopulmonary resuscitation (CPR) is an important skill for any parent to learn, but for those with babies or young children in intensive care who are at high risk for apnea, it is vital. That's why the children at Sacred Heart Medical Center in Spokane, WA, who are going home on oxygen, on a monitor, or with other medical problems that could cause breathing cessation are not discharged until parents have completed the CPR class. The class is open to anyone, but tends to be filled with parents who have children in the pediatric intensive care unit or neonatal intensive care unit.

Those who are required to take the class don't always want to cooperate, and this can be a teaching barrier. "It tends to be young moms, and I think they may be intimidated by the older moms," says **Connie Mutton**, RN, BSN, neonatal case manager at Sacred Heart. To overcome this barrier, Mutton often groups the younger moms together or she will have a young mom do the return demonstration after the rest of the class has left.

Non-English-speaking parents can pose challenges as well. To meet the needs of this group, Mutton and other instructors will arrange classes for parents individually or with other families that speak the same language. When the CPR instructors tried to incorporate non-English speakers into the regular classes with the English-speaking parents, it was confusing for everyone because the interpreter was a distraction, explains Mutton.

To make teaching non-English speaking parents easier, the Medical Center developed a Spanish version of its infant CPR film. There's also a one-page handout available with step-by-step instructions in Spanish, Russian, and Chinese.

While return demonstration always is important, it's even more important when teaching through an interpreter, says **Katie Gilleran**, RN, BSN, pediatric case manager at Sacred Heart Medical Center. It's the only way that the instructor can know for sure that the concept was clear to the parents. Often, cultural differences must be overcome to get both parents to demonstrate back. For example, sometimes it takes a little more time to get fathers in Hispanic cultures to demonstrate CPR on a doll because they usually don't do that sort of thing.

Interpreters need to be included in the teaching whenever the child has a complex medical issue, and it is important when teaching CPR to select one that is not only familiar with medical terminology, but CPR if possible. "Frequently with our Spanish-speaking families, I use an interpreter who is actually trying to become a CPR instructor, so I am very comfortable that she is teaching what I am saying," says Gilleran.

Practice makes perfect

Whether the parents speak English or not, it's important that they practice CPR techniques following the class. Therefore, using a documentation sheet, the CPR instructor checks off all the steps of CPR that the parent is able to do correctly during the return demonstration. For example, whether they can blow correctly or locate the mark to do the decompressions.

The form is sent to the intensive care unit, and a nurse completes it at the bedside with the parents transferring what they learned to their own baby. For example, parents would identify the baby's nipple line and show where they would place their fingers for CPR. "During this time, the nurse will ask questions such as, 'If you walk into the room, and your baby is blue, what are you going to do?' They just keep reinforcing the steps," says Mutton.

Also, parents are told to review the steps daily

SOURCES

For more information about teaching parents CPR, contact:

- **Katie Gilleran**, RN, BSN, Pediatric Case Manager, Sacred Heart Medical Center, W. 101 8th Ave., Spokane, WA 99220. Telephone: (509) 474-2177.
- **Connie Mutton**, RN, BSN, Neonatal Case Manager, Sacred Heart Medical Center, W. 101 8th Ave., Spokane, WA 99220. Telephone: (509) 474-2176. E-mail: MuttonC@shmc.org.

on their own. Mutton suggests that parents of premature babies ask themselves each morning while they are changing their baby's diaper, what they will do that day if their baby quits breathing, she explains. ■

When child is ill, teach parent-school partnership

Help them go back to school with coping skills

Integrating back into the school system during an illness can be a difficult period for a child, but it is essential for socialization, academic progress, and normalization, says **Melinda Coughlin**, MEd, school program manager at Children's Hospital of Philadelphia. "It's important that they are treated as kids first and we aren't looking at them as an illness," she says. However, due to the illness, there are frequently issues the child, family members, and school officials must deal with when a chronically ill child returns to school.

Some children need to develop coping strategies to manage their pain, such as relaxation techniques. Other children may have personal issues like the need to have frequent access to a restroom.

"It is essential to talk to the child, no matter what their age is developmentally. During the conversation, let the child voice what some of his or her worries or concerns are about returning to school," says Coughlin.

Also rehearse with children what types of questions they may get from their peers and how they might want to answer them. Young school children have all types of questions for their classmates, such as whether the illness is contagious or if they are able to do the same things they did before on the playground and in the classroom. Sometimes it is appropriate for children to say that they don't want to talk about it.

The Child Life and Education Department at Children's Hospital of Philadelphia offers an educational program for classmates where a staff member goes with the child to the classroom and does a short presentation on the illness if the family thinks this would be helpful. Usually, this is done when children's physical appearances are altered from treatment, such as when they have hair loss following chemotherapy or radiation or they have gained lots of weight while taking steroids.

Families need help in determining realistic expectations and identifying options that they can discuss with the school officials so that their child can participate. Often parents have a lot of anxiety, so it's important to discuss what would make them feel comfortable. Perhaps the school can keep a communication log for the parents so they know how the child does at school or make arrangements for the child to periodically check in with the school nurse, says Coughlin.

Parents also need innovative suggestions that they can approach the schools with that will help their child integrate into the school environment without feeling different. For example, if their child has to use the bathroom frequently, they might talk to the teacher about developing a sign the child can use when he or she needs to leave the classroom.

When working with schools, health care officials must identify what information school officials need and who needs to know, whether it is the school nurse, guidance counselor, or classroom teacher, advises Coughlin. "Most schools, when offered the suggestions, are very open to brainstorming solutions to problems. If the medical profession could try and meet the school officials' learning needs, then they would be able to help the child meet his or her learning needs," she says.

Also, it's a good idea to provide a contact person at the clinic, such as the nurse practitioner, so school officials can call for information. A lot of "what ifs" come up during discussion of re-entry, and it is important to point out that in most cases schools would respond just as they would with any child. For example, if the ill child fainted on the playground, they would handle the incident the same as they would any school child.

When children are chronically ill, they lose control of a lot of aspects of their lives. They don't control their treatments, hospital admissions, or the side effects from treatment options. "The school re-entry piece is an opportunity to give children some control over an important aspect of their life, and that is why it is important to include the child and family in looking at how to make that a reality," says Coughlin. ■

SOURCE

For more information about education revolving around school re-entry, contact:

- **Melinda Coughlin**, MEd, School Program Manager, Children's Hospital of Philadelphia, Child Life and Education Department, 34th and Civic Center Blvd., Philadelphia, PA 19104. Telephone: (215) 590-7512. E-mail: Couglin@email.chop.edu.